VOLUME 4 – QUALITY MANAGEMENT AND GRIEVANCE & APPEALS

Page

4-a1. Quality Management Function and Structure

CPSA promotes a service delivery system guided by the philosophy and principles of Performance Improvement (PI) while in compliance with applicable rules, laws, policies and procedures related to Quality Management (QM). As stipulated by contract with ADHS/DBHS, CPSA's QM activities encompass Title XIX/XXI and Non-Title XIX members, persons with serious mental illness (SMI), and the coordination of behavioral health services with acute and routine medical health care delivered by AHCCCS Health Plans and other applicable health care providers. CPSA is committed to system improvement rather than merely regulation.

PROPOSED IMPROVEMENTS/ADDITIONS TO THE QM STRUCTURE AND FUNCTIONING

Currently, CPSA has a Director, Performance Improvement and Quality Management (PI/QM), six Quality Management Coordinators, and two support staff members who perform all quality management monitoring for the behavioral health system in GSA 3 and GSA 5. The structure for Quality Management flows from the Board of Directors, to the CEO, to the Chief Medical Officer and then directly to the Director of PI/QM and staff who are responsible for carrying out the daily functioning and operations of Quality Management.

CPSA is proposing to streamline the overall CPSA and Comprehensive Service Network (Network) QM functions to avoid unnecessary duplicative reviews; provide real-time technical assistance and guidance at the Network and site level; and, to ensure all activities undertaken are for the purpose of improving the quality of care to members and meet all contract requirements. Currently, providers are responsible for ensuring contract compliance of their subcontracted providers; tracking, reviewing and trending all Critical Incidents, Complaints and Grievances and Appeals; credentialing and privileging all applicable staff; implementing their own QM/UM Plans; establishing their own performance improvement models; joining CPSA in Joint Site Reviews; conducting internal monitoring; establishing their own benchmarks; and, conducting their own focus reviews. These responsibilities are currently consuming much of the time of the Networks' QM Directors/Coordinators. On occasion, Networks have had to hire additional QM staff to keep up with the monitoring demands. Upon review and analysis, CPSA saw the potential to streamline some of these responsibilities to eliminate duplicative functions for the Networks. This will enable them to more clearly focus on their other administrative and clinical responsibilities.

The proposed changes will also enable CPSA to accomplish, at a minimum, the following:

- Establish a position within each Network that ensures the highest visibility and attention to quality management and utilization management activities congruent with CPSA's and ADHS/DBHS mission and goals.
- Alleviate expanded monitoring requirements from the Networks.
- Drill down monitoring to the Clinical Liaison level through an intensified direct and visible approach.
- Actively manage the Networks' credentialing and recredentialing functions.
- Actively guide the Networks' internal performance improvement activities to a more proactive approach, based on in-house data and information.
- Provide a systematic and consistent approach to monitoring and improvement throughout the behavioral health system, based on ADHS/DBHS and AHCCCS operational definitions, minimum performance standards, established goals, benchmarks, data sources and financial incentives.
- Quickly respond and attend to enhancements to the quality management system undertaken by ADHS/DBHS.
- Further facilitate CPSA and ADHS/DBHS reviews.

To implement the changes outlined above, CPSA will hire six Quality Management (QM) Liaisons who will be stationed for a minimum of 30 hours per week at the Network facilities to function, in part, as internal independent QM reviewers for the organizations and as reviewers for CPSA. These co-located positions will have the responsibility of all required direct monitoring for the behavioral health system at the practice level. This structure will enable Networks to more freely conduct the clinical business at hand, while increasing their monitoring and profiling capabilities to ensure ongoing internal improvements directed at the practice level.

QM FUNCTIONS OF THE COMPREHENSIVE SERVICE NETWORKS AND CPSA'S QM LIAISON

Networks will continue to perform those inherent QM functions that all organizations should perform. The Networks' inherent QM functions and the CPSA QM Liaison functions are outlined in Table 4-a1.1 on the following page.

Table 4-a1.1 Functions of CPSA Quality Management Liaison and the Networks	
CPSA QM Liaison Functions	**Comprehensive Service Networks' QM Functions**
• Pharmacy Data Aggregation • Peer Review Data Generation • Network Clinician Profiling • Joint Site Reviews with CPSA QM Coordinators • Credentialing and Recredentialing • MHSIP Coordination and Administration • Review and Technical Assistance regarding Subcontractor's QM Plans, Work Plans and Policies • Network Critical Incident Reports and Complaint Data Aggregation	• Implementation of Internal Improvements • Licensure Preparation/Plans of Action • Critical Incident Review and Reporting • Root Cause Analyses • Privileging of Clinicians • Peer Review • Internal Satisfaction Surveys • Medical Records • Risk Management Activities • Licensure Requirements

Daily monitoring activities will be undertaken by the QM Liaison, which will eliminate some of the most time-consuming duties currently being performed by Network QM Directors or clinical staff. This would further ensure that clinical and administrative time would be gained by the Networks to be able to augment their clinical and administrative oversight and Network-wide improvement efforts. QM Liaisons will report directly to the CPSA QM Liaison Supervisor; however, their activities will also be coordinated with the Network QM Directors or designees while they are on-site. This shift in reviewing responsibilities alleviates the need for providers to expend administrative budgetary resources to conduct ongoing internal case reviews, reviews of subcontracted providers, and focus reviews of providers as warranted by circumstances. This change will further ensure that different levels of administration are not being formed, implemented or instituted that could distract from the service goals of each of the Networks. CPSA will begin implementation July 2005 and by July 2006 will have this model fully operational with goals and objectives clearly delineated, and a program evaluation in place to determine if the model benefits the Networks and their overall performance.

QUALIFICATIONS OF CURRENT AND PROPOSED QM STAFF

CPSA has always been committed to hiring the most highly trained, qualified and competent staff. This commitment is especially evident for those individuals tasked with the overall QM functions. QM staff must be highly skilled in clinical areas, proficient in analyses of data and knowledgeable in change models.

1 FTE Director, Performance Improvement and Quality Management – The current director has a Ph.D. in Counseling Psychology, a Master's Degree in Education with a specialty in Counseling and Guidance and a Bachelor's Degree in Psychology. He is a national Certified Counselor and is nationally certified as a Health Care Quality Professional. The Director has over 13 years of direct oversight experience in QM programs in Arizona and over 20 years experience in behavioral health programs which span all ages and populations.

6 FTE Quality Management Coordinators – QM Coordinators, at a minimum, have a Master's Degree in Behavioral Health or a BSN with at least two years experience in Quality Management or Case Management. All current QM Coordinators have a strong knowledge base of Quality Management principles, clinical practices, program evaluation, program monitoring and excellent analytical skills.

1 FTE Quality Management Liaison Supervisor – QM Liaison Supervisor will meet the same qualifications as the QM Coordinators and will additionally have five years of supervisory experience.

6 FTE Quality Management Liaisons – QM Liaison staff, at a minimum, shall have a Bachelor's Degree in Behavioral Health or a BSN with experience in Quality Management or Case Management. These individuals shall all have a strong knowledge base of clinical practices, Quality Management principles, case file review or other monitoring experience, and data management and data presentation skills.

1 FTE Adverse Event Specialist – The Adverse Event Specialist, at a minimum, has a Master's Degree in Behavioral Health or a BSN with at least two years experience in Quality Management or Case Management. This individual must also possess a strong knowledge base of Quality Management principles, clinical practices, program evaluation, program monitoring and excellent analytical skills.

2 FTE Quality Management Support Staff – Both support staff positions are filled with competent individuals who have each functioned as a support staff for a minimum of five years. They have proficiency in data entry and retrieval, queries of the QM databases, ability to maintain tickler systems and the ability to coordinate all correspondence and ensure timely responses to requested data or information.

4-a2. Performance Improvement Model

CPSA'S PERFORMANCE IMPROVEMENT MODEL

CPSA uses the term Quality Management (QM) to encompass activities traditionally called Quality Assurance (QA), Continuous Quality Improvement (CQI), Performance Improvement (PI), Utilization Review (UR) and Risk Management (RM). CPSA's QM activities monitor behavioral health services and the coordination of these services with acute medical health care. CPSA's overall approach to quality management includes four major components:

1. Commitment from leadership and staff to establish an environment designed for continuous quality improvement.
2. Establishment of organizational goals supporting performance improvement.
3. Establishment of a core set of meaningful process and outcome measures to substantiate goal attainment.
4. Implementation of standardized organization-wide performance improvement processes.

Leadership Involvement

All components of CPSA's approach to quality management support a system of accountability and continuous performance improvement. The scope of CPSA quality management includes, but is not limited to, the establishment of a quality management structure throughout the CPSA system to prioritize, assess, plan, implement, monitor, evaluate and improve internal processes, overall system performance, and the appropriateness and effectiveness of care.

CPSA believes that to create an organization that demands and supports continuous improvement, CPSA leadership must be committed to the quality management process and directly involved with organization-wide quality management efforts. CPSA has such a commitment from its leaders. As evidence of this commitment and involvement, the Board of Directors delegates CPSA's Chief Executive Officer (CEO) the responsibility for ensuring the implementation of the Quality Management. Further, CPSA's Chief Medical Officer is charged with directing quality management functions and for approving all changes to the *CPSA Quality Management/Utilization Management (QM/UM) Plan* and *Work Plan*. The Director of Performance Improvement and Quality Management (PI/QM) is then responsible for the daily functioning of the QM area. Beyond this, both the Chief Medical Officer and the Associate Medical Director direct overall development, implementation and monitoring of treatment and service planning standards of care.

The Chief Medical Officer and Associate Medical Director provide input to senior management regarding system functioning and service needs, as well as training and technical assistance for service delivery, quality management, utilization management and practice guidelines. The Chief Medical Officer and Associate Medical Director also co-chair the QM Committee that is comprised of executive and management staff. It is through this structure that CPSA ensures that resources, education, understanding, and a mission and vision that embody performance improvement permeate the organization.

The staff commitment comes from the modeling provided by the leaders of the organization and by CPSA's commitment to training and fostering a learning environment. CPSA staff members are empowered in identifying, assessing, and addressing opportunities for improvement throughout the organization. All staff members are encouraged to participate in the performance improvement process. One mechanism is through staff participation on committees and sub-committees which helps to create ownership and pride in the QM process. One such sub-committee open to all CPSA staff is the Improving Organization-Wide Performance (IOWP) Committee. The purpose of this committee is for staff to identify opportunities to improve CPSA internal functioning, develop strategies for implementation, and carry out these strategies.

Performance Improvement Model

CPSA, in cooperation with DBHS, will participate in the ongoing monitoring and evaluation of the quality and appropriateness of member care delivered across its Provider Network. For the past four years, CPSA has used the FOCUS-PDCA Model, a nationally accepted PI model, as the consistent approach to carry out all performance improvement activities. CPSA chose the FOCUS-PDCA Model as it was assessed to better meet the needs of an organization of CPSA's scope and complexity. The FOCUS-PDCA Model is best described as a series of sequential steps that lead a team through a consistent and thorough methodology of improvement. This model further strengthens the commitment and involvement of CPSA's staff toward a common goal of improving the organization and improving services. The outline of the model is as follows:

- **F** = **Find** a process to improve. Develop an opportunity statement with beginning and ending boundaries and customers specified. Why is it important to improve this process now?

- **O** = **Organize** a team that knows the process. List team members with title, department and position. Are employees closest to the process on the team?
- **C** = **Clarify** current knowledge of the process. Develop a process flow chart; show clarification of the current process; and show obvious improvement, if any.
- **U** = **Understand** sources of process variation. Develop a cause and effect diagram; define key quality characteristics; describe/display initial data collection; and describe obvious improvements, if any.
- **S** = **Select** a potential process improvement. List and prioritize ideas for improvement. Which is the best one to work on first?
- **P** = **Plan** the improvement. Develop a description of a plan for action – who, what, where, when, why and how.
- **D** = **Do** the improvements. Define dates of implementation and describe any variation from the plan.
- **C** = **Check** the results. Review data collection and display and review lessons learned.
- **A** = **Act** to hold the gain. Compare with initial data; conduct assessment and yield conclusions; and implement action plan.

All indicators, thresholds, benchmarks, data collection, analyses, actions to be taken, and findings to be reported are consistent with the *DBHS QM/UM Annual Plan and Work Plan* and with AHCCCS and Centers for Medicaid and Medicare (CMS) guidelines. All CPSA staff members have been trained in the model and are using it to improve both internal and external processes. It is through continued use of this model and refinement of staff's skills in using it that CPSA continues to improve the behavioral health system throughout both GSA 3 and GSA 5.

CPSA is committed to the development and improvement of a comprehensive behavioral health system for its members. CPSA will continue to work in partnership with DBHS, AHCCCS, CMS, service providers, members and other stakeholders to identify areas for new performance improvement efforts.

Performance Improvement Activities in Accordance to Plan

CPSA has an extensive monitoring system that has evolved over the past nine years. This monitoring system was developed in collaboration with the Comprehensive Service Networks (Networks) and was specifically designed to streamline the monitoring process, eliminate duplicative reviews, and yield the maximum benefit to members. To ensure that CPSA's and each Network's performance improvement activities are conducted according to the plan and obtaining desired outcomes, CPSA has a central *QM/UM Plan* and *Work Plan* that serves as the template from which Networks are to develop their own. CPSA conducts a quarterly review of its own *QM/UM Plan* and *Work Plan* activities through the Quality Management Committee to ensure adherence to the *DBHS QM/UM Annual Plan and Work Plan*. CPSA reviews and accepts or rejects Network QM Work Plans if they fail to adhere to the guidelines delineated by the *DBHS QM/UM Annual Plan* and *Work Plan* and the *CPSA QM/UM Plan* and *Work Plan.* CPSA reviews quarterly updates of each Network's QM Work Plan activities during the Collaborative Technical Assistance (CTA) Team meetings to ensure adherence to these same requirements. CPSA also establishes the minimum performance standards to be incorporated into the QM Work Plans and reviews progress toward these quarterly through the QM Coordinators Committee meetings.

Performance Improvement Activities Obtaining Desired Outcomes

To ensure that CPSA and Network activities are obtaining the desired outcomes, it is first necessary to establish mutually agreed upon goals, ensure that these goals match the goals in the *DBHS QM/UM Annual Plan and Work Plan*, develop specific achievable objectives, establish interventions for meeting these objectives, establish incremental milestones for each objective to demonstrate progress, establish a point of responsibility, and establish expected timeframes for completing each of the milestones. This is the methodology used in *CPSA's QM/UM Plan* and *Work Plan* to institute a consistent system that lends itself to producing measurable outcomes.

Through the quarterly reviews of each of the Network's QM Work Plans, CPSA can ensure continued success in meeting the established goals, objectives, milestones and timeframes. When interventions are not meeting the desired outcomes, Work Plans are changed.

In adherence to the FOCUS-PDCA Model, CPSA will continue to track all activities to their completion, adjust activities that are not producing the desired effect, monitor these activities, and assess whether they are meeting the desired incremental goals.

4-a3. Stakeholder Involvement in Quality Management

At CPSA, stakeholder involvement is seen as paramount to the success of the organization. From its inception, CPSA has incorporated stakeholder input into its overall design, purpose, and ultimate implementation of a system of care that continues to transform the behavioral health system in Southern and Southeastern Arizona. This commitment to stakeholders is carried throughout the Quality Management (QM) and Utilization Management (UM) functions. CPSA adheres to the QM philosophy that direct involvement of those most impacted by any change or process improvement is vital. It is this commitment that continues to strengthen CPSA's standing in the communities that it serves. In obtaining early and continuous involvement from representatives of various stakeholder groups, CPSA has imparted a sense of ownership into the process whereby stakeholders know that their input shapes the system. Over the years, stakeholders have made great contributions to system development processes and improvements in the CPSA system of care.

CPSA'S VISION OF QUALITY MANAGEMENT

CPSA's vision of quality management is the successful implementation of, and participation in, a performance improvement process dependent on long-term commitment and effort from all areas of the system of care. This commitment begins with the Board of Directors who appoints the Chief Executive Officer (CEO) as responsible for ensuring the implementation of the Quality Management program. This responsibility is shared by the CEO with the CPSA Chief Medical Officer who is responsible for directing the QM functions and for approving all changes relevant to the QM system. Both the Chief Medical Officer and the Associate Medical Director lead the overall development, implementation, and monitoring of treatment and service planning standards while the Director of Performance Improvement and Quality Management directs the daily functioning of the area.

CPSA's Quality Management (QM) Committee is the main conduit of change for the organization. The QM Committee is co-chaired by the Chief Medical Officer and the Associate Medical Director (Children's Medical Administrator) and is the venue used to impart quality management, utilization management and other information to CPSA's senior management, as well as to implement needed changes. The majority of CPSA's subcommittees channel their information, input and involvement from stakeholders through the QM Committee.

CPSA STAFF PARTICIPATION

The participation of staff includes the CEO, senior management, and all other CPSA staff members who have embraced a performance improvement program that encompasses the entire organization and its Provider Network. All senior managers are members of the QM Committee in order to ensure that all facets of the organization are represented. Beyond this, CPSA maintains the Improving Organization-Wide Performance (IOWP) Committee which is open to all CPSA staff to ensure that when processes are changed, implemented or improved, the people most affected are involved. As an example, through this committee and subsequent focus groups, staff made the recommendation to hire a staff person who would focus exclusively on the cultural competency and diversity of the CPSA Provider Network. This has contributed to CPSA's ability to operationalize the *CPSA Cultural Proficiency Strategic Plan*. Table 4a-3.1, Venues for CPSA Staff Participation into CPSA's QM Process, identifies the many mechanisms available for CPSA staff to have input into the QM system.

Table 4-a3.1
Venues for CPSA Staff Participation into CPSA's QM Process

• Improving Organization-Wide Performance Membership	• Suggestion Box
• Formulation of Annual Goals for Each Functional Area	• Identifying Areas for Improvement
• All Staff Meetings	• Work Groups
• Monthly General Staff Meetings	• Performance Evaluations
• Annual Staff Survey	• Trainings
• Annual Building Bridges Cultural Competency Survey	• Staff Complaints
• Collaboration Meetings	• Network Design & Improvement Committee

MEMBER AND FAMILY PARTICIPATION

The active participation of members and their families is extremely vital to CPSA's functioning. It is through the input of members and their families that CPSA is able to impact the system in a responsive and meaningful way which leads to improved member outcomes. It is important to CPSA that members and their families have a variety of ways to become involved in providing direction and input into clinical and other processes that impact them directly. One avenue is through the Board of Directors where members may become involved as full members or guests, or as members of

committees and/or Community Councils. Another example of member input occurred during the last Mental Health Statistics Improvement Program (MHSIP) survey process in which, in addition to being involved in item selection at the state level, members and their families were consulted by CPSA in refinement of the implementation of the survey. See Table 4-a3.2, Venues for Member and Family Input into CPSA's QM Process, for additional venues for member and family input.

Table 4-a3.2
Venues for Member and Family Input into CPSA's QM Process

• Board of Directors Meeting (as Board Members)	• Mental Health Statistics Improvement Program (MHSIP) Survey Results
• Board of Directors Committees (as Board Members e.g., Program & Planning, Finance and Human Resources, Public Policy, Community Councils)	• Member Services Tracking System (MSTS) Tracking Sheets (Aggregate Data)
• Stakeholder Meetings (e.g., Community Forums)	• Work Groups
• Training Evaluations	• Performance Improvement Initiatives
• Annual Events (e.g., Family Forum)	• Requests for Advocacy
• Complaints	• MHSIP Planning Meetings
• Grievances	• Critical Incident/Mortality Trends

NETWORK AND SUBCONTRACTED PROVIDER PARTICIPATION

CPSA is committed to receiving and incorporating feedback and input from its Provider Network. Provider staff members also have an opportunity through CPSA's governing structure to become full members of the CPSA Board of Directors as well as members of Board committees, such as the Program and Planning Committee. All new initiatives are taken to the Program and Planning Committee for approval; therefore, membership on this committee provides a powerful mechanism for provider staff input. See Table 4-a3.3, Venues for Network and Subcontracted Provider Input into CPSA's QM Process, for provider input mechanisms.

Table 4-a3.3
Venues for Network and Subcontracted Provider Input into CPSA's QM Process

• Board of Directors Meeting	• Provider Trainings
• Board of Directors Committees (e.g., Program & Planning, Finance, Human Resources, and Public Policy)	• Biennial Network Reviews
• CEO Meetings	• Impromptu Issue-Specific Meetings
• QM Coordinators Meetings	• Work Groups
• Medical Directors Meetings	• Performance Improvement Initiatives
• Information Technology Directors Meetings	• Complaints
• CFO Meetings	• Grievances
• Contracts Improvement Meetings	• Member Services Contacts
• Research and Evaluation Meetings	• QM Contacts
• Collaborative Technical Assistance Team Meetings	• Ongoing Technical Assistance
• All Provider Meetings	• Joint Site Reviews

PARTICIPATION BY OTHER STAKEHOLDERS

CPSA believes that without the support of the external stakeholders, success cannot be achieved. It is through receiving and incorporating such input that CPSA can continue to refine a behavioral health system that is responsive to the needs of its members and other agencies that serve them. CPSA has maintained excellent working relationships with various state agencies including Arizona Department of Corrections (ADOC), the Courts, Child Protective Services (CPS), and the Division of Developmental Disabilities (DDD). CPSA embarks on ongoing performance improvement activities and always involves the stakeholders that will be impacted. An example of this is the Arizona State Hospital Performance Improvement activity regarding State Hospital overuse, in which the police department, judges, the crisis system, the physicians involved in court-ordered evaluations and court-ordered treatment, and members and their families were all invited to attend and participate. It is through inclusive efforts such as these that CPSA hears from key stakeholders and ensures their support for and ongoing participation in new initiatives or systems change.

4-a4. Reconciling Accreditation Requirements and Contract Terms

NATIONAL ACCREDITATION, POTENTIAL CONFLICTS WITH CONTRACT COMPLIANCE AND NETWORK SUFFICIENCY

CPSA does not intend to be accredited by any national organization for this bidding cycle or subsequent bidding cycles. CPSA will relinquish its Accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) before the end of the current contract year on July 1, 2005. CPSA has determined that the Office of Behavioral Health Licensing (OBHL), DBHS and AHCCCS standards provide the needed structure for continued member assessment and success. CPSA will use only those performance standards and indicators that are in compliance with DBHS and AHCCCS mandates. Along with this, CPSA will continue to implement internal performance improvement indicators to ensure that internal processes are of the highest quality and that accurate, timely, and complete data are used to make all business and clinical decisions. CPSA will continue to expeditiously add providers despite their accreditation status in order to fully meet the needs of members and their families.

4-a5. Dissemination and Communication of Quality Management Information

The goal of any dissemination plan should be to provide information that is comprehensive, meaningful, relevant, timely and useful to the recipients. CPSA differentiates between data and information in the following ways: data are defined as a collection of facts that come in various forms which, prior to conversion, encompass computerized, pictorial, graphic, aggregate and oral methods. Information, on the other hand, is defined as an interpreted set of data that is collected, synthesized, and organized to provide a basis for decision making. CPSA views both data and information as reusable resources that may lead to implementation of a variety of improvements.

CPSA holds that all information made available to its stakeholders should meet the following criteria: information should be timely, accurate, and consistent and should be continually tested, assessed and improved in order to ensure that it continues to be relevant and useful. Following are some examples of shared Quality Management (QM) data and other information:

- **DBHS Performance Standards and Expectations** (e.g., Statewide Key Indicators, Policies, etc.) – are reports and other documents shared by CPSA with Network providers and CPSA staff as soon as they are received from DBHS in order to maintain a focus on statewide priorities. These are shared through ongoing correspondence and meetings of the QM Coordinators, Collaborative Technical Assistance (CTA) Teams, and the QM Committee.
- **CPSA Plans, Work Plans and Evaluations** – are developed and submitted to DBHS for approval. Beyond this, CPSA shares all these plans and work plans and evaluations with Network providers so that they may use these as templates by which to design their own plans, work plans and evaluations.
- **CPSA Performance Reports** (e.g., *Administrative Review*, *Independent Case Review* [ICR], *Mental Health Statistics Improvement Program* [MHSIP] survey results, etc.) – are shared within CPSA and with its Networks through ongoing meetings and through the CTA Team process.
- **Comprehensive Service Network (Network) Performance Reports** (e.g., *Comprehensive Service Network Provider Performance Profiles*, *Network Provider Biennial Review*, *Biennial Joint Site Review*, etc.) – are shared with DBHS, CPSA staff, and Networks to provide guidance and supervision to the Networks through the CTA Team process, ongoing meetings, and evaluation of the Network's performance.
- **QM Monitoring Results** (e.g., review, tracking and trending of incidents/mortalities, grievances and appeals, complaints, etc.) – are shared with the Networks on a quarterly basis and annually with DBHS. Internally, results are shared with staff quarterly.
- **QM Data** (e.g., accessibility indicators, credentialing/privileging data, credentialing/privileging files, matches between credentialed and privileged staff, and assignment as Clinical Liaisons, etc.) – are continuously shared with providers. These data are used to make real-time changes in the system so that they are corrected and members receive timely care by credentialed and privileged individuals.
- **Utilization Monitors** (e.g., *Persons with Serious Mental Illness Determination*, *Notices*, *Level of Care*, etc.) – are data shared with Networks through the CTA Team process to ensure that they are following all timelines associated with these processes.
- **Utilization Data** (e.g., penetration, utilization, prescription costs, Arizona State Hospital census, etc.) – are data elements shared with CPSA staff and Networks on an ongoing basis and form the cornerstone of the Network Design and Improvement Committee (NDIC), which uses these data to identify and address gaps in services. These data are used to identify over/under utilization of services, track and attend to rising costs in medications, and address the Arizona State Hospital Liaison function.
- **New Initiative Rollout Plans** (e.g., performance improvement projects, Arizona Vision and Principles, recovery principles, *ADHS/DBHS Assessment and Service Planning Guidelines*, etc.) – are part of the information that CPSA shares through trainings, meetings and the CTA Team process. These are theoretical frameworks on which CPSA bases monitoring efforts.
- **Additionally, CPSA uses a variety of methods by which to share information.** Some of these methods include direct technical assistance, formal and informal meetings, reports, data submissions, telephone calls, e-mails, formal correspondence, plans of corrective action, the Web site, and handbooks.

CPSA's complex, yet comprehensive practices for communication and disseminating QM information flow, to DBHS, CPSA providers, members/family members and other stakeholders is a dynamic and responsive process as depicted in Figure 4-a5.1, Effective Quality Management Information Dissemination, on the following page.

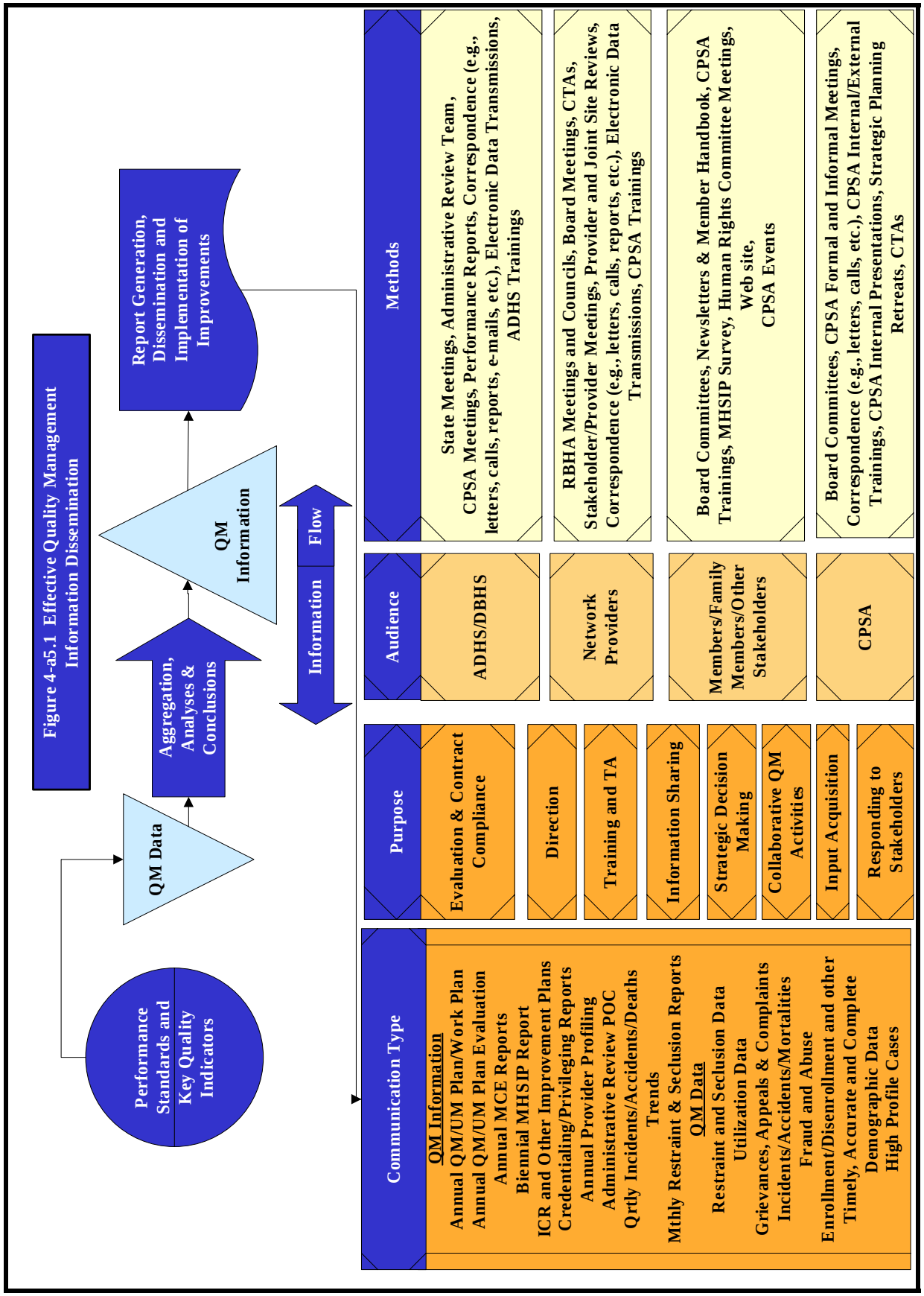
Figure 4-a5.1 Effective Quality Management Information Dissemination
Performance Standards and Key Quality Indicators
QM Data
Aggregation, Analyses & Conclusions
QM Information
Report Generation, Dissemination and Implementation of Improvements
Information Flow
Communication Type
Purpose
Audience
Methods
QM Information
Annual QM/UM Plan/Work Plan
Annual QM/UM Plan Evaluation
Annual MCE Reports
Biennial MHSIP Report
ICR and Other Improvement Plans
Credentialing/Privileging Reports
Annual Provider Profiling
Administrative Review POC
Qrtly Incidents/Accidents/Deaths Trends
Mthly Restraint & Seclusion Reports
QM Data
Restraint and Seclusion Data
Utilization Data
Grievances, Appeals & Complaints
Incidents/Accidents/Mortalities
Fraud and Abuse
Enrollment/Disenrollment and other
Timely, Accurate and Complete
Demographic Data
High Profile Cases
Evaluation & Contract Compliance
Direction
Training and TA
Information Sharing
Strategic Decision Making
Collaborative QM Activities
Input Acquisition
Responding to Stakeholders
ADHS/DBHS
Network Providers
Members/Family Members/Other Stakeholders
CPSA
State Meetings, Administrative Review Team, CPSA Meetings, Performance Reports, Correspondence (e.g., letters, calls, reports, e-mails, etc.), Electronic Data Transmissions, ADHS Trainings
RBHA Meetings and Councils, Board Meetings, CTAs, Stakeholder/Provider Meetings, Provider and Joint Site Reviews, Correspondence (e.g., letters, calls, reports, etc.), Electronic Data Transmissions, CPSA Trainings
Board Committees, Newsletters & Member Handbook, CPSA Trainings, MHSIP Survey, Human Rights Committee Meetings, Web site, CPSA Events
Board Committees, CPSA Formal and Informal Meetings, Correspondence (e.g., letters, calls, etc.), CPSA Internal/External Trainings, CPSA Internal Presentations, Strategic Planning Retreats, CTAs

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4-a6. Use of Information Sets and Reports

INFORMATION SETS/REPORTS TO IDENTIFY AREAS IN NEED OF IMPROVEMENT

CPSA currently uses a myriad of information sets and reports to identify areas in need of improvement. The current process uses the Performance Improvement (PI) model to identify, select, prioritize and implement performance improvement strategies and processes. CPSA's Quality Management (QM) is able to effectively and efficiently address issues through performance improvement activities for the following:

- For planned activities based on CPSA's mission, vision and guiding principles, ADHS/DBHS and AHCCCS initiatives, the Arizona Vision and Principles, *ADHS/DBHS Clinical Guidance Documents*, the President's New Freedom Commission on Mental Health report, the recovery model principles, and *National Standards for Culturally and Linguistically Appropriate Services (CLAS)*, etc.;
- For anticipated activities based on the future direction of behavioral health either nationally (e.g., consumer movements, Centers for Medicare and Medicaid Services [CMS], National Institute of Mental Health [NIMH], etc.) or at the state level;
- As needs occur or are discovered (e.g., trends in incidents/accidents/deaths, results of provider monitoring, trends in member complaints, trends in member grievances and appeals, ADHS/Health Services Advisory Group [HSAG] Independent Case Review findings, Mental Health Statistics Improvement Program [MHSIP] survey results, Administrative Review findings, Office of Behavioral Health Licensing (OBHL) Review findings, trends in utilization, trends in penetration, network sufficiency reports, staffing needs, staff surveys, etc.); and
- Upon others identifying needs for the system (e.g., members, family members, ADHS/DBHS, AHCCCS, Center for Disability Law, CPSA functional areas, Quality Management (QM) Committee, Executive Management Team (EMT), the Board of Directors, other stakeholders, etc.).

Ultimately, members and their outcomes are the impetus for the identification and undertaking of all CPSA performance improvement activities. From a quality management standpoint, it is understood that performance improvement activities should be undertaken when there is at least one anticipated positive outcome identified. CPSA asks the following questions when deciding whether the information is truly guiding CPSA toward a performance improvement opportunity:

- Will this Performance Improvement produce faster, easier ways to do the same thing?
- Will this Performance Improvement yield ways to do them better?
- Will this Performance Improvement provide CPSA with ways to increase effectiveness?
- Will this Performance Improvement yield productivity or efficiency increases?
- Will this Performance Improvement remove obstacles to performance?
- Will this Performance Improvement reduce the potential for problems or errors?
- Will this Performance Improvement promote excellence?

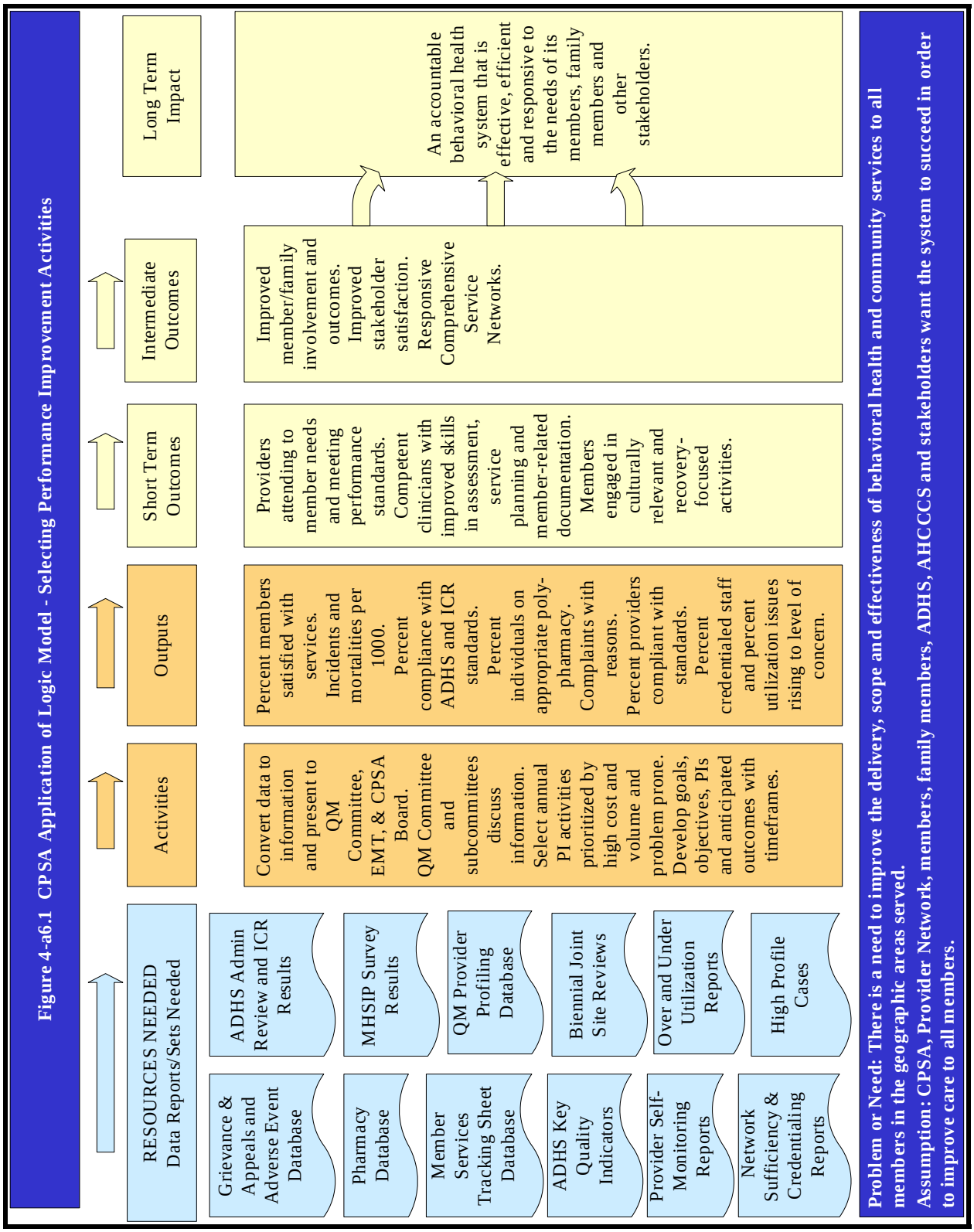
When an affirmative answer is reached for any of these questions, performance improvement activities are then prioritized; selected; planned with indicators established to determine success; implemented with anticipated outcomes to establish direction; assigned a person or persons responsible to ensure accountability; and, attributed anticipated timeframes for completion.

Rationale Used in Prioritizing Performance Improvement Activities

Given that, at any given point in time, opportunities for improvement and potential performance improvement activities may arise, it is important that CPSA apply prioritization criteria for any proposed performance improvement activity. CPSA's QM Committee prioritizes all performance improvement activities based on a set of pre-established criteria designed to maximize staffing, resources, and potential member outcome. These include those services that are high volume, high-risk, problem-prone, or for causes such as failures in processes are brought to CPSA's attention.

CPSA has embraced the *DBHS Logic Model for Network Sufficiency Analysis (Logic Model)* as a viable vehicle for not only measuring and assessing planned activities but for planning upcoming performance improvement activities in the most systematic, complete, and thoughtful manner. By planning activities in this manner, CPSA is able to establish performance improvement activities that delineate an overall goal, objectives and resources needed; a systematic measurement and assessment component with established thresholds for the objectives; timelines for completing the objectives; a methodology for implementing real-time improvements; and a methodology to measure the effectiveness of the performance improvement activities once they are completed. The core data sets and reports, activities and anticipated short and long term outcomes are delineated in Figure 4-a6.1, CPSA Application of Logic Model – Selecting

Performance Improvement Activities, using the *DBHS Logic Model*. As can be seen, it is through this careful planning methodology that CPSA proposes to undertake all performance improvement activities to demonstrate a thorough, thoughtful and effective process.



4-a7. Ensuring Complete, Timely, and Accurate Quality and Utilization Management Data

The overall information goal is to have data that are current, complete, accurate and relevant for Quality Management (QM) and Utilization Management (UM) purposes. CPSA has adopted DBHS' definitions of timeliness, accuracy and completeness as follows:

- **Completeness** – All required information shall be fully disclosed in a manner that is both responsive and pertinent to report intent with no material omissions.
- **Timeliness** – Reports or other required data shall be received on or before scheduled due dates.
- **Accurate** – Reports or other required data shall be prepared in strict conformity with an appropriate authoritative source.

USE OF DATA AND INFORMATION

CPSA believes that data need to be validated for timeliness, completeness and accuracy as well as for their clinical integrity. Without these validity checks, data cannot be used with any degree of confidence for decision making regarding programmatic or organizational direction. CPSA will continue to perform data validation and reconciliation through DBHS. Currently, DBHS collects discrepancies and reports these to the RBHAs. CPSA finds this vital to the continuance of Performance Improvement (PI) activities. Beyond this, CPSA continues to improve its management information system to be more responsive to the needs of its users. Timeliness indicators for data entry and accuracy have been incorporated into the QM internal monitoring function; therefore, these indicators will continue to be used to maintain the internal integrity of the data. CPSA will also conduct clinical validation of these data based on a sampling methodology to support the following:

- Clinical outcome achievement through review of housing status, employment status and education status;
- Changes implemented in service plans to ensure that the data are current and clinically relevant;
- Assignment and continued follow-up with members, through their Clinical Liaisons, based on level of covered services received by members; and
- Changes in the *Global Assessment of Functioning* or *Children's Global Assessment Scale* scores over time and ensuring that services are based on severity of symptoms and functioning.

SYSTEMS, PROCESSES AND MECHANISMS IMPLEMENTED TO MEET STANDARDS

CPSA continues to implement and assess the effectiveness of processes designed to validate data and verify information prior to using these in the decision making process. To reduce and eliminate the existence of data and information that do not meet standards, CSPA has implemented a multi-tiered data validation process by which data are reviewed, tested, validated, and verified complete and accurate. CPSA has also implemented mechanisms to ensure that data and information remain of the highest quality, integrity, validity and reliability. These data are consistently assessed to ensure that all protocols have been followed. This multi-tiered process includes the following components:

- A systematic approach to defining all data elements to be collected by the information system with clearly defined data specifications.
- Pre-established thresholds for data compliance and a regular system of report generation, corrective action and improvement processes to ensure data timeliness, accuracy, and completeness.
- Pre-established consequences for incomplete, incorrect and late data submission by providers.
- Training provider and internal staff at inception of data collection projects and throughout the course of the data collection to ensure consistency of understanding and data entry and consequences for the provider if these are not consistently met.
- An information system design which implements edits and safeguards against incorrect, late or null value data entry into required and vital data fields and forces providers to correct data in real time.
- A data reconciliation system that enforces continuous correction and improvement in data submittal by identifying the agencies or individuals responsible for the errors; identifying the corrective action necessary, including sanctions; and, provision of corrective and educative training and technical assistance opportunities.
- An information system that, following entry of data into the system, tests the most vital data and generates reports to providers explaining errors, requiring that data be corrected and initiating follow-up to ensure that providers continue to improve in their data submission.

- A system that enforces consequences to providers for incorrect, incomplete and late data and shares the application of such consequence with all providers to continue to reinforce the need for attention to these issues.
- A system by which QM and UM continue to pull samples for review and continue to have providers correct data in these samples. Every sample drawn has data correctness, completeness and timeliness components to it so that data are continuously improved.
- Continued discussion and corrective action implemented through ongoing Collaborative Technical Assistance (CTA) Team meetings with Networks, crisis and detoxification providers, and other providers which generate and input the data.
- Continued use of the data system to report process and outcome measures that clearly delineate the percent of accuracy, correctness and completeness of data to ensure successful decision making and continue to reinforce the need for continued attention.

SAMPLING, PROVIDING FEEDBACK AND CORRECTIVE ACTIONS

Within the validation process by which data are reviewed, tested, validated and verified complete and accurate, CPSA proposes the following sampling, feedback and corrective action protocol for each of the main data sources:

- Report generation will be conducted on 100 percent of data to test for timeliness, accuracy, and completeness. Reviews will be conducted, at a minimum, on a quarterly basis and providers will be required to correct all deficiencies within one quarter. Scores derived from these reports will be used to implement financial and other incentives in line with DBHS. Beyond this, these scores, prior to being corrected, will be used as major indicators on the Annual Network Performance Profiles.
- CPSA's information system design implements edits and safeguards on 100 percent of data in a continuous stream, with edits paralleling the edits implemented by DBHS. CPSA will continue to implement, at a minimum, such edits. However, CPSA will continue to review and identify areas in data submission which could best be addressed by such edits and implement these as warranted.
- CPSA's data reconciliation system is based on 100 percent of data with reports generated at least monthly. These reports are not only put on the server for providers to use in their reconciliation process, but also are presented in the Collaborative Technical Assistance (CTA) Team meetings. This allows for increased understanding by all involved in coding, inputting, extracting, and analyzing these data for use in determining clinical outcomes and other process outcomes for providers. It is only through this full understanding of the significance of data that clinical and network sufficiency analyses can be conducted.
- CPSA's QM and UM areas regularly, but no less than quarterly, pull either convenience or representative samples for record reviews. Beyond mere record identification, CPSA's QM and UM staff use these opportunities to correct deficiencies in data. The Annual Provider Profile is one example of this and CPSA has consistently used a 95 percent confidence interval (+ or – 7% error sample) per Network per population served. When data discrepancies are identified, they are pointed out to providers who are expected to correct the deficiencies in the data system to reflect the clinical presentation of member or other fields as found in the member clinical record. This ensures that at least annually, a representative sample is used to determine the Provider Performance Profile scores. Other samples vary in size; however, corrective actions are required of providers and implementation of these corrective actions is followed to completion though the CTA Teams, which are used as CPSA's main conduit for change at the practice level.

It is only through these processes of data error prevention, avoidance, and correction that CPSA and its Networks can continue to ensure that data are consistently accurate, timely and complete. It is only by keeping these issues at the forefront that data will continuously be attended to at all levels of the organization and throughout the Provider Network, and the behavioral health system can continue to demonstrate accountability and ongoing successful outcomes to all stakeholders.

4-a8. Process and Focus of Provider Monitoring and Performance Improvement Activities

PROCESS FOR PROVIDER MONITORING

CPSA's ultimate goal for provider monitoring and performance improvement activities is to improve the quality of care to members. CPSA adheres to the DBHS philosophy that services are: 1) to be delivered with the explicit goal of assisting people to achieve or maintain recovery, gainful employment, success in age-appropriate education, return to or preservation of adults, children and families in their own homes, avoidance of delinquency and criminality, self-sufficiency and meaningful community participation; 2) continuously evaluated and modified if they are ineffective in helping to meet these goals; 3) to be delivered by behavioral health practitioners that instill hope in even the most disabled that achievement of these goals is a desirable and realistic possibility; and, 4) provided in a culturally competent and linguistically appropriate manner.

CPSA adheres to the principles of quality management and strongly believes that the improvements begin with first ensuring the existence of sound structures to support the activities at hand, which then leads to the development and implementation of processes designed to carry out the planned activities. Once both structures and processes have been designed and implemented, these inevitably lead to improved outcomes. It is through this construct that all CPSA's monitoring efforts are developed, implemented, and followed through to completion. See Figure 4-a8.1, QM Construct.

FOCUS OF PROVIDER MONITORING

CPSA derives its focus for monitoring from DBHS and AHCCCS initiatives, new directions and best or promising practices. *ADHS/DBHS QM/UM Plan* and *Work Plan* clearly delineate the direction taken by the state and behavioral health care systems throughout the nation. Some recent guidelines include the President's New Freedom Commission on Mental Health report, the Office of Minority Health's *Culturally and Linguistically Appropriate Standards (CLAS)*, the Arizona Vision and Principles, and the recovery model principles.

Figure 4-a8.1 QM Construct

CPSA has established an extensive, multi-pronged monitoring system where reviews are intended to address some or all components of the quality triangle. CPSA remains focused on Title XIX/Title XXI eligibles and persons with serious mental illness (SMI) and continues to prioritize services to these populations for monitoring and performance improvement activities; however, CPSA's monitoring system also incorporates all other populations in the CPSA system of care. Examples of monitoring efforts along with the constructs they are designed to monitor are found in Table 4-a8.1, CPSA Monitoring Reviews.

Table 4-a8.1 CPSA Monitoring Reviews

Review	Structure	Process	Outcome
Biennial Network Reviews	X	X	
Biennial Joint Site Reviews	X	X	
Focus or Specialized Reviews	X	X	X
Biennial MHSIP Survey	X	X	X
Annual QM Provider Profiles		X	X
Quarterly Credentialing and Privileging Reviews	X	X	
Annual Cultural Competency Self-Assessments	X	X	
Monthly Accessibility Management Monitoring	X	X	
Annual Comprehensive Service Network Profile	X	X	X
Medical Care Evaluation Studies	X	X	X
Drug Utilization Patterns	X	X	X
Review/Trending of Incidents/Accidents/Deaths	X	X	X
Approval of Provider QM Plans and Work Plans	X	X	
Practice Pattern Monitoring		X	

Table 4-a8.1 CPSA Monitoring Reviews			
Review	**Structure**	**Process**	**Outcome**
Utilization Reviews	X	X	
SMI Determination Monitoring	X	X	X
Seclusion and Restraint Monitoring	X	X	X
Over/Under Utilization of Services Monitoring	X	X	X

Beyond normally occurring provider monitoring activities, CPSA's Quality Management closely tracks, trends and analyzes negative outcomes that may be indicators of a failing system or that could be an indication of members being denied necessary resources and services. These data are collected and analyzed, and improvements are implemented based on these analyses.

In monitoring, CPSA has always focused on the special needs of persons with a serious mental illness (SMI) given that their illness potentially predispose them to being taken advantage of or becoming victims of abuse and/or neglect. Given the requirements and directives that stemmed from the Arnold vs. Sarn lawsuit, the issues revolving around persons with SMI remain in the forefront of all CPSA monitoring efforts. To exemplify these efforts, CPSA reviews and conducts full and thorough reviews of all mortalities of persons with SMI and trends and tracks all incidents involving this population. When further investigation of incidents is warranted due either to their severity or to the fact that they demonstrate that sufficient reviews and investigations have not been conducted to prevent or to eliminate these types of incidents, CPSA conducts investigations and implements corrective actions with providers based on its findings. Beyond this, all grievances, appeals and complaints are tracked and resolved to the best outcome for persons with SMI. Complaints are also tracked, trended and resolved with attention paid to the best outcome for the member.

CPSA engages in focus reviews designed to improve or maintain the highest quality of care for persons with SMI served within CPSA geographic service areas. Examples of these have been provided above and others are:

- QM Provider Profiles inclusive of Recovery, Case Management and the Assessment of Special Assistance;
- Level of Care Monitoring, Prior Authorization and Concurrent Review Monitoring, and Notices Monitoring;
- Outcome Measurements (e.g., changes in the Global Assessment of Functioning and other outcome indicators such as housing, work involvement, and use of substances derived from the CPSA data system etc.);
- Number of Service Providers by Type; Number of Services by Type and by Population; and Percent of Grievances and Appeals; and
- Geo-mapping to determine areas of need for persons with SMI.

TARGETED PROVIDER PERFORMANCE IMPROVEMENT ACTIVITIES

Given CPSA's extensive, multi-pronged monitoring system, much of the focus for performance improvement activities is based on improving the results of the monitoring conducted by CPSA and DBHS. These performance improvement activities tend to be attempts at implementing or improving structures or processes that are Network-specific and designed to continue to improve monitoring results. Examples of Network-specific performance improvement activities are the implementation of electronic tickler systems to ensure timeliness of coordination of care efforts; providers are moving toward electronic records to streamline many of these processes; and, some providers are implementing cues into the Informed Consent Form to ensure that all vital elements of the consent have been addressed by physicians. Whenever these efforts are evaluated as successful, CPSA shares these best practices with other providers to facilitate these processes at their sites.

CPSA engages providers in system-wide performance improvement activities. Usually, these activities are designed to roll-out DBHS initiatives such as the *Assessment and Service Planning Guidelines, the Coordination of Care Policy* and forms, the *Informed Consent Policy* and standardized format; however, at other times, these performance improvement activities are designed to improve the service delivery to members. One example of a system-wide performance improvement effort is the Arizona State Hospital Performance Improvement activity that resulted in the formation of the Carondelet Extended Care Unit in Pima County to reduce Arizona State Hospital use. Representation at this performance improvement activity included CPSA's Chief Medical Officer and Associate Medical Director, judges, police officers, and county attorneys. Another example is the Intake Performance Improvement activity that led to the collection and tracking of all referrals into the system. This was a significant undertaking given that for the first six months, providers needed to collect all data manually. These data are now collected by CPSA's data system with improvements noted on an ongoing basis. CPSA engages in performance improvement activities based on DBHS' direction for behavioral health or on deficiencies discovered by CPSA. All performance improvement activities have the goal of improving care and services to members.

4-a9. Utilization Management Function and Structure

UTILIZATION MANAGEMENT SCOPE AND GOALS

The Institute of Medicine's *Crossing the Quality Chasm: A New Health System for the 21st Century* defines "micro-systems" as "units delegated to perform certain processes with specific desired results" that should be made responsible and accountable for achieving quality care within the organization. The CPSA Utilization Management (UM) program functions as a micro-system in promoting quality behavioral health care outcomes for CPSA members, families, providers, stakeholders and the community. The Arizona Vision and Principles, the recovery model principles, the *DBHS Quality Management Guiding Principles,* and the six goals of quality care improvement in the President's New Freedom Commission on Mental Health report are incorporated into the design and implementation of the CPSA UM program to ensure quality care. This is evidenced first and foremost in the UM program commitment to collaborative, cooperative relationships with members, family members, providers and other stakeholders who have a leading role in decision-making about services, coupled with an expectation of current best practice and a system focus on the delivery of quality behavioral health care.

To accomplish the goals as elaborated in the annual *CPSA Quality Management/Utilization Management Plan* and *Work Plan (QM/UM Plan),* the CPSA UM program utilizes a Performance Improvement (PI) strategy, the FOCUS-PDCA Model, with Networks, facility providers and community-based providers to ensure participation and involvement of providers, members and their families, primary care physicians, and other state agencies and service partners in the coordination of care. The PI model is used to identify gaps in the provider network service continuum, to develop and promote best practices and to provide information about UM processes and outcomes to members, families, providers and stakeholders. Through the PI approach, the CPSA UM program targets the key UM outcomes of compliance with federal regulations for use of Title XIX and Title XXI funds and notice requirements; reduced admissions and readmissions to Level I services; and, the development of an integrated, accessible, recovery-oriented and culturally competent continuum of care. At the same time, in sharing information about UM processes and outcomes, CPSA UM contributes to an improved behavioral health care system through increased member, family, provider and stakeholder access to and use of information about best practices, services and service providers.

UTILIZATION MANAGEMENT STRUCTURE

The UM structure is purposefully designed to improve the quality of professional care, delivery systems and organizations and to improve the behavioral health care experience for the members and their families, providers, and the community. The UM system components include: the *QM/UM Plan*; the Utilization Review (UR) system (including prior authorization and continued stay review); monitoring of compliance with 42 CFR; coordination of discharge planning by the Comprehensive Service Networks' (Networks') clinical staff or Clinical Liaisons; development and dissemination of best practice guidelines; coordination of data collection efforts to reduce duplication and ensure quality and compliance with federal and state requirements; development and management of guidelines for new medical technologies and new uses of existing technologies; and, UM performance evaluation of outcomes that are data-driven and performance-based for inpatient care and other covered services.

The CPSA UM system is described in the CPSA *QM/UM Plan* which is submitted annually to AHCCCS through DBHS for review and approval. The CPSA Board of Directors has ultimate authority for governance and approval of the *QM/UM Plan*. Under the umbrella of Performance Improvement and Quality Management (PI/QM) and through the mechanism of the Quality Management (QM) Committee, the Chief Medical Officer guides the UM functions, including the overall development, implementation and monitoring of UM activities. Through the Executive Management Team (EMT), the Chief Medical Officer contributes to the development of CPSA's annual strategic issues and goals, and identifies plans for and progress towards the six aims for quality improvement as outlined in the President's New Freedom Commission on Mental Health report. The Network Design and Improvement Committee (NDIC), a subcommittee of the QM Committee, reviews data provided by UM regarding over/under utilization. The Utilization Review (UR) Committee, a subcommittee of the QM Committee, includes representation by provider staff and CPSA UM, Member Services and QM staff. The UR Committee meets monthly to review utilization review processes and data; present focused utilization studies for discussion; identify utilization trends and problem areas; and, make recommendations for system performance improvement.

The written *QM/UM Plan* includes a description of the structure, activities and functions of the UM system as well as a plan of evaluation of outcomes. The CPSA *QM/UM Plan* meets federal (42 CFR) and state requirements for use of federal and state funds in providing behavioral health services to Title XIX and Title XXI recipients and is reviewed annually at a minimum. Utilization Management activities are structured to ensure that no person takes part in the review of any case in which the reviewer has a financial interest or has been or is professionally involved. At the same time,

CPSA upholds the value of communication and coordination of information about best practice, provider utilization, authorization criteria and UM activities to members, families, providers and the community, where appropriate, to create incentives for system performance improvement and to advance the development of best practice knowledge. Providers are encouraged to advocate on behalf of members within the UM process. Network Providers review aggregate UM information, made available to authorized provider staff on ProvNet (a CPSA-developed secure Web portal allowing the end user to perform member searches, access claims information, file upload and download, and perform advanced ad hoc reporting through a secure SSL 128-bit encrypted connection), and make recommendations for improvement. While electronic means of information sharing is used where possible, protected health information (PHI) is kept confidential in accordance with applicable federal and state laws including A.R.S. § 36-2403 and CPSA confidentiality policies.

UTILIZATION REVIEW SYSTEM

The Utilization Review (UR) System is directed by the CPSA Chief Medical Officer. At the core of the CPSA UR system is the belief that services are best determined through the person-centered approach of the Adult Clinical Team and the Child and Family Team. This core tenet informs the Chief Medical Officer in establishing UR policy and developing criteria to be used in the review process, as well as in directing Physician Advisors in the application of the criteria and policy when making utilization decisions. Additionally, the Chief Medical Officer provides oversight to the Utilization Review process through review of individual cases when needed or requested by the Physician Advisors and collaborates with Network Medical Directors and CPSA Physician Advisor staff to identify opportunities for improvement of care processes and utilization of resources.

CPSA will contract with a group of psychiatrists equivalent to approximately two (2) FTEs for Physician Advisors who are board-certified, provide psychiatric peer review of cases with potential for denial at the request of the UR Specialist, conduct reconsideration review when requested by the inpatient psychiatrist or the Network psychiatrist and make denial decisions as the designee of the Chief Medical Officer. Physician Advisors provide direction and consultation to CPSA UR staff related to the authorization of service. Only CPSA Physician Advisors or the CPSA Chief Medical Officer can deny authorization for initial or continued stay for a prior-authorized service and only after reconsideration review of the case. The complement of Physician Advisors will include board-certified child and adolescent psychiatrists as well as psychiatrists with national certification in addiction psychiatry or equivalent training and experience in the treatment of persons with substance use disorders.

The number of CPSA Utilization Review Specialists is dependent upon a number of factors, including but not limited to, the average daily census and average length of stay in Level I facilities, travel time to and from the various facilities, and the overall demand for services in Level I facilities. CPSA estimates it will hire six (6) FTE Utilization Review Specialists, who are licensed Behavioral Heath Professionals and have earned the credential of Certified Professional in Heathcare Quality (CPHQ) or have equivalent training and experience. The estimate of six staff members is based on the historical CPSA average daily census of 110 persons in Level I care facilities from which members and their families may choose to receive services. As average daily census decreases, staffing will be adjusted. Staff will prior authorize admission and conduct continued stay review for Title XIX and Title XXI recipients and Non-Title XIX/ Non-Title XXI members with serious mental illness (SMI) in Level I facilities according to DBHS service authorization criteria. In addition to prior authorization and continued stay review, UR staff will coordinate discharge planning and continuing care provided by the Network clinical staff or Clinical Liaisons. UR Specialists coordinate case discussion with the inpatient treating physician and the Physician Advisor, when necessary, to determine or corroborate findings related to medically-necessary covered services. Under the supervision of the Utilization Management Manager, the Utilization Management Office Assistant (1 FTE) will perform assigned tasks that ensure that Level I facilities and providers meet the 42 CFR requirements for Certificate of Need (CON) and Recertification of Need (RON) and plan of care requirements. The Utilization Review Data Specialist (1 FTE) will produce a variety of utilization reports including some that will be used by CPSA staff in the overall management of Level I utilization. These reports also will be used by NDIC and the QM Committee in the evaluation and management of under/over utilization.

PRIOR AUTHORIZATION AND CONCURRENT REVIEW

The President's New Freedom Commission on Mental Health report addresses a number of issues, including the safety of the member; timely access to the most appropriate services; coordination and communication among member, family and providers; efficient utilization of resources and effective methods of ensuring best practice. To that end, CPSA UR Specialists facilitate coordination and communication efforts among Level I facilities, Networks, crisis services providers and members and their families that support rapid assessment of the member's immediate needs during an emergency situation when a member presents in a licensed (Office of Behavioral Health Licensing [OBHL]) Level I inpatient or urgent care facility. Prior authorization is never used for emergency admissions. At the earliest opportunity

and in collaboration with the treating facility or crisis staff, the member's needs are assessed and the least restrictive, most community-based and appropriate plan to which the member and family agree is implemented.

For planned, non-emergent placement in Level I facilities (inpatient, sub-acute or Residential Treatment Centers [RTC]), CPSA UR staff members prior authorize requests for placement based on the Adult Clinical Team's or Child and Family Team's decision. If the Adult Clinical Team or Child and Family Team determines that Level I placement is needed, the Team will develop an initial service plan, including treatment goals and discharge criteria, prior to placement and forward this plan to the CPSA UR Specialist for prior authorization. If the member is under 21 years of age and the request is for Level I RTC, the CON is completed by a team that is independent of the facility and includes a physician who is knowledgeable of the individual's situation and who is competent in the diagnosis and treatment of mental illness, and the CPSA UR Specialist then issues an initial prior authorization for up to the thirty days.

When a member is admitted to a Level I inpatient or sub-acute facility on emergent basis, the CPSA UR Specialist follows-up within 24 hours (or the next business day if a weekend or holiday intervene) of notification of admission. The UR Specialist reviews for authorization of continued stay using approved ADHS/DBHS Prior Authorization and Continued Stay criteria. If criteria are met, an initial length of stay is assigned along with a date for review of continued stay. If criteria are not met or the Specialist anticipates challenges in the continued stay reviews, the case is referred to a CPSA Physician Advisor for review. The Physician Advisor may direct the UR Specialist to obtain further information or may discuss the case directly with the attending inpatient psychiatrist and/or the Network outpatient psychiatrist if one has already been assigned. If the criteria for continued stay are not met, then the Physician Advisor must speak with the attending inpatient psychiatrist and Network psychiatrist and allow them to present further information in support of continued stay. If such support is not forthcoming or is insufficient, then the Physician Advisor will issue a denial of continued stay with an effective date of the denial. Facilities are notified of authorization decisions verbally within one hour of request and in writing within 24 hours of request or expiration of an existing authorization and upon presentation of a completed CON or RON. RTC stays are reviewed every 30 days for purposes of recertification of need and authorization of continued stay.

During the inpatient stay, every effort is made to address the immediate needs of the member and family during the crisis and to identify the member's and, in the case of children or adolescents, the child and family's readiness for self-advocacy in the development of an individualized recovery care plan. The UR Specialist coordinates with network staff to ensure a timely and appropriate discharge plan including a follow-up physician appointment, if receiving medication, and care management plan using recovery model principles and identifying appropriate referrals to promote the member's recovery and resilience. Peer Support (Recovery) Specialist staff, employed through direct contract with consumer-run organizations, engage the member and family during the inpatient stay to develop a crisis and care management plan and support the member in self-advocacy with treatment team staff. In the process of continued care planning, the member or guardian is provided Notice of discontinuation of coverage and the Right to Appeal in a timely manner. Decisions to deny a prior-authorized service are made by the CPSA Chief Medical Officer or CPSA Physician Advisor and only after extensive efforts are made to coordinate written or verbal communication between the Physician Advisor and the treating physician for further consideration of the decision. The member or guardian is provided notice of the right to appeal a denial decision according to the AHCCCS and ADHS//DBHS standard.

Prior authorization is also required for non-formulary medications, combinations of selected medications and/or for quantities of medication that exceed a thirty-day supply or exceed quantity limits that are set to promote cost-efficient prescribing. CPSA provides 24-hours-a-day, 7-days-a-week capability of prior authorization for medications within 24 hours of request to ensure continuity of care for the member. When a prior authorization is requested, it is submitted to CPSA Pharmacy Services for approval. Approval may be granted by the CPSA Pharmacy Services Manager or designee; denial may only be made by the CPSA Physician Advisor or Chief Medical Officer. When a request results in a denial of prior authorization, the member/guardian is notified according to AHCCCS and DBHS requirements.

Monitoring of Compliance to 42 CFR and UM Monitoring

CPSA ensures monthly and quarterly monitoring of the 42 CFR process for 100 percent compliance with federal regulations governing the use of Title XIX and Title XXI funding. Notice requirements for the provision of notices upon prior authorization and discontinuation of care in a Level I facility are also monitored. Using a Performance Improvement model and the DBHS Administrative Review tool, the UR Supervisor provides clinical review and oversight of UR Specialist staff performance to ensure that standards are met. CPSA met this standard in the *ADHS/DBHS 2004 Administrative Review*.

CPSA UM staff works in collaboration with Network staff to avoid duplication and to collect, analyze and report data from retrospective review. Through its Collaborative Technical Assistance (CTA) Team model, CPSA UR staff members work alongside Network clinical staff members to improve and assure compliance with required requirements. This model allows for improved understanding of and training on all federal and state requirements as well as promoting immediate performance improvement strategy development at the practice level. CPSA UM conducts inter-rater agreement tests annually at a minimum for UR Specialists who conduct admission and continued stay reviews to ensure reliable and valid use of criteria.

Coordination of Discharge Planning by Level I and Network Clinical Staff

The Utilization Data area produces computerized aggregate information which, when analyzed and compared over time, is useful in identifying patterns and trends that describe special population needs, expected service utilization patterns and significant variation from expected service patterns. For special needs populations, such as persons with serious mental illness (SMI) or children who are seriously emotionally disturbed or those with co-occurring medical or substance use disorders and/or involvement with the Division of Developmental Disabilities (DDD) system, Child Protective Services (CPS) or the forensic system, it is particularly crucial to ensure safe, effective, person-centered, culturally competent, equitable and timely behavioral health services. For these special populations, timely and effective care coordination and case management are required to ensure appropriate care planning, timely referral and service delivery upon admission and following discharge from Level I services. The challenges in so doing may include identification of gaps in the care continuum, need for expansion of existing service or specific technologies to accomplish the goals of the Adult Clinical Team and Child and Family Team. Frequently, communication and collaboration with other care providers requires the committed oversight and communication skills of CPSA UR staff to accomplish the mutual goals in a timely manner.

To more effectively and efficiently respond to the needs of special populations, the CPSA UR Specialist coordinates and communicates with the outpatient clinical team, the inpatient team and the Physician Advisor to ensure that discharge planning and obstacles to post-discharge care are addressed as soon as possible in the care process. Networks prioritize CPSA UR Specialist requests for discharge planning and subsequent care to ensure the care experience is the least restrictive for the member and that the recovery process is facilitated at the earliest possible time.

Evidence-based Practice Guidelines

The CPSA UM program also participates in the development and dissemination of practice guidelines to ensure the most effective and efficient use of resources in the provision of care to the member and family. Guidelines are based on reasonable medical evidence or a consensus of behavioral health care professionals. Guidelines are developed, adopted and reviewed in consultation with Network professionals, and are consistent with DBHS guidelines and technical assistance documents. Guidelines are available on the CPSA Web site and are shared and reviewed with members and families to further the decision-making process in planning care. New medical technologies and new uses of existing technologies are guided by policies and procedures developed with input from members, families and providers and include consideration of federal and state coverage rules, practice guidelines, payment policies and utilization management that allow for individualization of service plans.

UM Program Evaluation

CPSA UM evaluates the *QM/UM Plan's* accomplishments annually and presents to the QM Committee for comment and to the Board of Directors for approval. The evaluation is based on analysis of the effectiveness of Utilization Management activities and processes to meet the identified goals of provision of behavioral health services that are safe, timely, person-centered, efficient, effective and equitable. CPSA UM anticipates reporting that covered services, and particularly inpatient services, are based on best practices and that they are integrated, coordinated and reflect the preferences, values and needs of the member and family. These outcomes will be identified through evidence of reduced admissions and readmissions; compliance with 42 CFR and notice rules and regulations; evidence of continuity of care throughout the inpatient stay and transition to outpatient follow-up care process; reduced provider and member appeals; and, with the participation of stakeholders.

4-a10. Monitoring of Over/Under Utilization of Covered Services

OPERATIONAL DEFINITIONS OF OVER/UNDER UTILIZATION

CPSA views the monitoring and management of over/under utilization as directly related to fiscal accountability and quality of care. CPSA has adapted the Centers for Medicare and Medicaid Services (CMS) definition of over/under utilization to recognize the unique role of the member and family in determining the necessity of certain therapeutic services. The definitions follow:

> "Under utilization occurs when services are not offered or provided that could generally be expected to be helpful in assisting the member/family in achieving therapeutic goals and meeting needs as established in the behavioral health assessment and service plan. Over utilization occurs when services are offered and provided that are excessive or beyond what is needed for the member/family to achieve stated goals and meet needs as established in the behavioral health assessment and service plan."

In order to evaluate service demand across populations and programs, CPSA applies the principles of the *DBHS Logic Model for Network Sufficiency Analysis (Logic Model)* using data which includes, at a minimum:

- Measures of adherence to best practices;
- Historical utilization (including number of units and dollars expended);
- Enrollment and penetration stratified by age, gender, program type, and payer source;
- Grievance and appeal;
- Mortality and critical incident;
- Member complaint and requests;
- Denial of service logs; and
- Member satisfaction surveys and other stakeholder input.

Application of this model, in conjunction with the development of minimum network standards, defines the expected utilization of covered services within a quality framework. The *Logic Model* is used to guide the selection of data sources; review practice patterns and provider organization and structural information; and, identify the analysis process used to develop the hypotheses about the sufficiency and quality of the CPSA behavioral health system.

PROCESSES

Data first undergo aggregate analysis to establish validity for completeness, accuracy, and timeliness. CPSA's Network Design and Improvement Committee (NDIC) evaluates the data using comparative statistical methods to identify variance from expected performance and reviews it over time for trends or patterns. The NDIC reports its analytic findings to the CPSA Quality Management (QM) Committee. If variance from expected performance is established, CPSA engages in discussion with providers through the Collaborative Technical Assistance (CTA) Team meetings to identify the root cause for the variance. The CPSA QM Committee requests corrective actions from providers, when indicated. When analysis of available data suggests a deficiency in the sufficiency of the network, CPSA QM Committee presents the issue for discussion and decision making to the CPSA Executive Management Team (EMT).

The processes used to monitor over/under utilization include daily, weekly, monthly and quarterly methods of developing and reviewing information. This information is used to inform CPSA and stakeholders about how well the behavioral health system is responding to member needs and stakeholder initiatives; anticipating future needs; and, ensuring members receive care that is evidence-based best practice. The three primary processes include Utilization Review; aggregate data review and comparative analysis; and, information sharing and consultation with stakeholders.

Utilization Review

Utilization Review (UR) is conducted as a daily process for Level I and pharmacy requests for service as described in response 4-a9. Concurrent pharmacy UR is accomplished through Drug Utilization Review (DUR) programming in the pharmacy online adjudication system that contains the prior authorization requirements approved by DBHS and by review of prior authorization requests through the CPSA Physician Advisors. Utilization Review data are aggregated and trended monthly and quarterly for review.

Aggregate Data Review and Comparative Analysis of Case Management and Other Covered Services

The CPSA Utilization Data area analyzes and reports data for review of over/under utilization that are valid, accessible to the reviewer, and useful in providing information to those making decisions about the delivery of behavioral health services. Data validity is assessed through methods that ensure data completeness, accuracy, and timeliness, including

review of frequency of values, ratio of reported-to-expected values, edits for missing values and logical comparison within and between data sets as well as comparison to historical data. Data validity is assessed and evaluated in coordination with CPSA System Development and Evaluation, Information Technology, and Business Operations staff members, as well as providers and other stakeholders to ensure accuracy and consistency of analysis and reporting.

CPSA utilizes descriptive and inferential statistics in the analysis of provider practice patterns and utilization of covered services by population and fund source using service encounter data including, but not limited to, the number of units of each covered service, the provider of the service, place of service, and encounter value (as a measure of cost) of the service. Cost of services is analyzed by looking at the aggregate cost of all covered services as measured by the reported encounter values and then further analyzed to determine the cost on a per member/per month (PMPM) and per utilizer/per month (PUPM) basis by program type. Further analysis may be considered for special populations or by demographic variables. For example, not all members need or receive medication services. Therefore, the PUPM provides a different measure of the actual consumption or cost of providing medication services to members who are receiving them in contrast to the more traditional PMPM, which includes members who are not receiving medication services. On a quarterly basis, the Utilization Data area prepares reports that list each covered service with the information stated above. The services are then aggregated by domain as specified by DBHS for analysis. CPSA also focuses on developing comparative data for special population needs, access to care, evidence of culturally competent services and best practices. Data are analyzed for trends or patterns to detect the presence of over/under utilization and for further inquiry and comparison with other data sets. When available, CPSA uses established state and federal benchmarks or expectations; however, since there is an absence of nationally recognized, and evidence-based managed behavioral health utilization benchmarks, CPSA has elected to use its own historical data to establish performance benchmarks when others are not available.

Services reported as "case management" are analyzed to assure that other covered services are not inadvertently included in that category. As reported to DBHS during the 2004 Annual Administrative Review, CPSA has discovered that a number of providers have been reporting other support services such as Personal Care Services, Peer Support Services, Respite Care, and Therapeutic Foster Care Services as Case Management Services. Such reporting would suggest the under utilization of those particular services and the over utilization of case management services. Through the Collaborative Technical Assistance (CTA) Team process, CPSA has been and will continue to provide technical assistance to the providers in the correct coding and reporting of all covered services.

Pharmacy data are analyzed by the CPSA Pharmacy and Therapeutics Committee which is chaired by the Chief Medical Officer and coordinated with the Pharmacy Services Manager. Other members include the Network Medical Directors from GSA 3 and GSA 5, the Medical Director of the community-wide crisis services provider in GSA 5 and the Medical Director of the detoxification services provider located in GSA 5, as well as representatives of the contracted pharmacies in both GSA 3 and GSA 5.

Information Sharing, Consultation and System Improvement

CPSA presents information for internal and external review of over/under utilization for consultation, feedback and recommendations for further action from stakeholders about the data presented. Variances from expected performance are addressed through the CTA Team process to identify the root causes of the variance and develop an improvement plan and subsequent monitoring plan.

Data are presented within CPSA to the NDIC which reports its findings to the CPSA QM Committee. Findings are shared with providers through the CTA Team process to develop hypotheses about the causes of variation and the relationship of data sets that may indicate network sufficiency, contract compliance, quality of care, service adequacy, and provider and program selection and modification. This information is used for further system development and evaluation. When over/under utilization is detected, CPSA works collaboratively with the Comprehensive Service Networks (Networks) to address variations from expected practice and to identify strategies to improve the provision of behavioral health care. When the analysis identifies a Network insufficiency, QM forwards the issue with recommendations to the Executive Management Team (EMT) for disposition.

CPSA provides immediate feedback to Networks on some utilization elements through ProvNet, a CPSA-developed Web portal providing secure encrypted file upload and download and reporting capability to provider end users with authorized access (login and password). CPSA also produces regular ad hoc reports distributed to the Networks and other providers. These reports are used by the CTA Teams with each Network and the community-wide crisis services provider in GSA 5 and the community detoxification services provider in GSA 5 to identify areas where over/under utilization are occurring and to develop plans for improvement and subsequent monitoring of the improvement plan.

4-b1. Meeting Notice Requirements

Through ongoing training, technical assistance and monitoring, CPSA ensures that the entity responsible for an action or other appealable decision provides and documents timely, appropriate notice according DBHS policy. Responsibility for these training, assistance and monitoring activities is shared by the Office of Grievance and Appeals (OGA), Quality Management (QM) and Utilization Review (UR). The entity responsible for providing notice depends on the type of service involved and the population served. CPSA does not provide notices to persons who are not eligible for either Title XIX/Title XXI services or services to persons with serious mental illness (SMI).

The CPSA OGA has primary responsibility for training both CPSA and Comprehensive Service Network (Network) staff on notice requirements. Trainings provide information needed by staff to comply with notice requirements, such as circumstances requiring notice, timeframes for providing notices, forms used and how to complete and deliver those forms. All trainings emphasize that notices must meet language and format requirements necessary to satisfy the communication needs of the member and that free oral interpretation in non-English languages must be provided to explain the information contained in the notice. Trainings reinforce that staff must explain the notice and appeal process to members and must not take punitive action against a member who requests an appeal or a provider who supports that request. Monitoring results are reported to the CPSA QM Committee and Executive Management Team (EMT) and shared with Collaborative Technical Assistance (CTA) Teams for review and improvement action.

LEVEL I SERVICES

CPSA UR is responsible for decisions regarding denial, suspension, reduction and termination of Level I services for Title XIX/Title XXI members and Non-Title XIX/XXI persons enrolled in services for persons with SMI. CPSA UR staff provides timely notice of those decisions. A CPSA UR Specialist receives and reviews all requests for authorization of Level I services. When questions arise about admission criteria, the UR Specialist confers with the CPSA Chief Medical Officer or Physician Advisor who contacts the admitting physician to discuss the case. If the responsible CPSA physician denies authorization, the UR Specialist completes and dates the appropriate notice form and obtains the physician's signature. If the member is Title XIX/Title XXI eligible, the UR Specialist uses a *Notice of Action*. If the member is enrolled in the program for persons with SMI, but is Non-Title XIX/XXI, a *Notice of Decision and Right to Appeal* is issued. The UR Specialist adds commonly understood language specifying the decision, the reason for the decision and its effective date, and sends the notice by certified mail to the member or authorized representative. CPSA considers any request for authorization of Level I acute and subacute services as warranting an expedited authorization decision and provides notice within three working days of the request. Notice of denial of a request for a Level I Residential Treatment Center is provided within 14 days of the request, unless the circumstances demonstrate the need for an expedited authorization decision. If an extension of either timeframe is required, the UR Specialist completes and delivers to the member a *Notice of Extension of Timeframe for Service Authorization Decision Regarding Title XIX/XXI Behavioral Health Services*. The UR Specialist then forwards a copy to the assigned Network for inclusion in the member's clinical record. The UR Specialist also notifies the requesting provider of CPSA's decision in writing.

The UR Specialist assigned to a particular facility issues either a *Notice of Action* or *Notice of Decision and Right to Appeal* upon reduction, suspension or termination of a previously authorized Level I service. The UR Specialist reviews the need for continued stay and coordinates discharge planning with Clinical Liaisons, the facility, and the member or authorized representative. Decisions to reduce, suspend, or terminate Level I services are made in conjunction with the facility and member, and CPSA UR staff personally delivers notice forms as part of the treatment planning process. If the member concurs in writing with the decision or the facility physician prescribes the change, notice is provided on the date of the proposed action, otherwise the UR Specialist complies with the standard timeframes required by DBHS policy. When personal delivery is not possible, the UR Specialist provides timely notice to the member by certified mail, sends a copy to the Network for inclusion in the member's clinical record, and notifies the requesting provider of the decision in writing.

The CPSA OGA provides, at minimum, biannual training on notice provision requirements to CPSA UR and Network staff involved in the Level I authorization process. Notice requirements are included in orientation for all new employees and the Utilization Management (UM) Manager provides ongoing training and supervision to UR staff. The OGA and UM Manager are available to provide ongoing technical assistance. Under the direction of the UM Manager and UR Supervisor, UR Specialists conduct informal, monthly reviews of a sample of notice forms to ensure compliance on an ongoing basis, and conduct formal monitoring combined with technical assistance on a quarterly basis.

MEDICATIONS THAT REQUIRE PRIOR AUTHORIZATION

CPSA requires prior authorization of certain medications, combinations of selected medications, and certain doses above those typically used for the treatment of a behavioral health disorder. CPSA Pharmacy Services provides prior authorization of medications. When questions arise about requested medication meeting authorization criteria, the Pharmacy Manager confers with the CPSA Chief Medical Officer or Physician Advisor who discusses the request with

the prescriber. Pharmacy denials are made by the CPSA Chief Medical Officer or Physician Advisor. CPSA Pharmacy Services staff complete and send appropriate notice forms to members or authorized representatives with a copy to the assigned Network. Networks provide notice of the reduction, suspension or termination of a prior authorized medication. These decisions are made by the clinical team, in conjunction with the member, and required notices are personally delivered to the member during a treatment planning session. If personal delivery is not possible, certified mail is required. The CPSA Pharmacy Services Manager provides ongoing training and supervision of internal staff responsible for notice provision and conducts monthly monitoring of a sample of notice forms.

INITIAL ELIGIBILITY FOR SERVICES FOR PERSONS WITH SMI

CPSA's Clinical Operations functional area has the combined responsibility of entering initial SMI eligibility decision information into the DBHS Client Information System (CIS) and providing applicants or their authorized representatives with notice of those decisions. Immediately upon completion of an SMI determination, the Network forwards the results to a CPSA Provider Services Representative who enters appropriate information into CIS and, within two days of the determination, sends the applicant or authorized representative a *Notice of Decision and Right to Appeal* by certified mail. The Provider Services Representative sends a copy of the notice form to the responsible Network for inclusion in the person's clinical record and documents provision of the notice in an internal CPSA database used for ongoing tracking and monitoring. The Director of Clinical Operations provides ongoing training and supervision of staff responsible for providing these notices.

OTHER NOTICE REQUIREMENTS

The CPSA OGA delivers a timely *Notice of Action* by certified mail to a Title XIX/XXI eligible person or a *Notice of Decision and Right to Appeal* to a person enrolled in services to persons with SMI when timeframes for resolving an appeal or complaint are not met.

Networks provide their members with all other required notices and document the provision of a:

- *ADHS/DBHS Notice of SMI Grievance and Appeal Procedure* to a person at the time of application for SMI eligibility determination.
- *Notice of Legal Rights for Persons with Serious Mental Illness* at the time a person enrolled in the program for persons with SMI enters the Network.
- *Notice of Decision and Right to Appeal* for a person with SMI when:
  - A decision is made regarding fees or the waiver thereof;
  - A standardized service plan demonstrates disagreement with any or all of the Non-Title XIX/XXI covered services offered;
  - In situations where it is impossible to develop a revised standardized service plan, a decision is made to reduce, suspend or terminate a Non-Title XIX/XXI covered service not requiring prior authorization; or,
  - A decision is made that a person is no longer eligible for services to persons with SMI.
- *Notice of Action* to a Title XIX/Title XXI eligible person when:
  - A standardized service plan demonstrates disagreement with any or all of the Title XIX/Title XXI services offered;
  - A denial or limited approval of a requested Title XIX/Title XXI covered service that does not require prior authorization is made;
  - A decision is made to reduce, suspend or terminate a previously approved Title XIX/Title XXI covered service that does not require prior authorization;
  - The Network is unable or fails to provide a Title XIX/XXI covered service in a timely manner; or,
  - A denial is made of a request to receive services outside of the provider network for persons in rural areas.
- *Notice of Discrimination Prohibited* to a person upon discharge from a Network.
- *Notice of Extension of Timeframe for Service Authorization Decision Regarding Title XIX/XXI Behavioral Health Services* when a Title XIX/XXI member requests an extension or the Network needs additional information and an extension is in the member's best interest.

The CPSA OGA provides at least quarterly Notice training to Network staff and is available for ongoing technical assistance, both in person and by telephone. Training emphasizes that service decisions should be made by Child and Family Teams or Adult Clinical Teams and incorporated into standardized treatment plans as part of the ongoing treatment planning process. Therefore, Networks should deliver the majority of notices personally at the time of a treatment planning session. In situations where personal delivery is impractical, Networks deliver notices by certified mail within required timeframes and maintain a copy in the member's clinical record. In conjunction with Network staff, the CPSA OGA conducts quarterly Notice monitors, which incorporate technical assistance. Network compliance with notice provision is also evaluated as part of CPSA's annual QM Provider Profile, during which CPSA QM staff review clinical records for documentation of required notice forms.

4-b2. Grievance and Appeal Functions

Responsibility for all grievance and appeal functions resides within the CPSA Office of Grievance and Appeals (OGA), which is staffed with three full-time positions: a Grievance and Appeals Supervisor, a Grievance and Appeals Specialist and a Grievance and Appeals Office Assistant. CPSA Legal Counsel provides representation at State Fair Hearings, but is not a part of the OGA. The CPSA Chief Medical Officer provides supervision of the OGA, and both the Chief Medical Officer and the Associate Medical Director provide consultation to the OGA and participate in the decision making process. No aspect of the grievance and appeal function is delegated or subcontracted.

The OGA is responsible for the development, ongoing revision and implementation of written internal procedures that govern the processing of all Title XIX/XXI appeals, SMI and Non-SMI/Non-Title XIX/XXI appeals, SMI grievances and provider claims disputes. The OGA ensures that CPSA-specific information concerning the grievance and appeal process contained in the *DBHS Provider Manual* is accurate and complete. All CPSA procedures directing internal and provider actions and responsibilities in the grievance and appeal area are reviewed by the OGA on an ongoing basis for compliance with applicable state and federal laws, as well as DBHS rules and policies.

In addition to the substantive processes, described in response 4-b3 and used by the OGA to facilitate resolution of appeals and grievance investigations, the OGA maintains and follows written internal procedures for administrative functions. For example:

- The OGA maintains and follows written internal procedures governing case docketing requirements that comply with DBHS policies and enters required information into the DBHS Office of Grievance and Appeals database in accordance with the *Office of Grievance and Appeals Database Manual*. Initial entries and required updates to the database are made within three days of the event requiring entry.
- Written internal procedures consistent with DBHS requirements govern the content, compilation, maintenance, confidentiality, secure storage and retention of appeal case records and grievance investigation records. OGA staff adheres to internal guidelines governing access to these records by a member and their timely provision to the DBHS OGA in cases where appeal beyond the CPSA level is requested. Internal guidelines also govern the content of the written summary and appeal case record and the timeframes required for forwarding those documents to the AHCCCSA Office of Legal Assistance (OLA), in the event that a request for a State Fair Hearing in a Title XIX/XXI appeal is filed.
- Written internal procedures direct that all notices and documents relating to the grievance or appeal process are either personally delivered or mailed by certified mail. Alternate delivery methods are identified and used upon a member's request or a determination that it is unsafe to contact the member at home.

The CPSA OGA ensures that written translations of notice and other appeal documents are available in Spanish, which is the prevalent non-English language spoken within both GSA 3 and GSA 5. Free, oral Spanish interpretation is provided at appeal and informal conferences when necessary. The OGA arranges provision of free, oral interpretation services in other languages to explain information contained in notices and other appeal process correspondence and to allow members to participate in appeal and informal conferences. The OGA also ensures that alternative formats, such as TTY (Teletypewriter), can be accessed when needed and notice and other written documents related to the appeals process are made available in alternate formats such as Braille, large font or enhanced audio.

CPSA OGA develops and provides ongoing training for provider and internal CPSA staff on members' rights to file complaints, appeals and grievances. These trainings delineate staff responsibilities to educate members about the complaint, appeal and grievance processes; to provide timely, written notices of members' rights to file appeals; to assist members in filing complaints, appeals and grievances; and, to cooperate and participate in CPSA's efforts to resolve or investigate all of these matters. The trainings emphasize that provider staff members are encouraged to use their best efforts to attempt resolution of problems at the provider level, but they must ensure that members are advised of their right to file complaints, appeals and grievances directly with CPSA and are assisted in doing so upon request. Provider personnel are instructed that they must not take punitive action against any person who chooses to file a complaint, appeal or grievance with CPSA.

The CPSA OGA also coordinates ongoing trainings for members, legal guardians, family members and community stakeholders on member rights, including the right to file and the process to use when filing complaints, grievances and appeals. OGA personnel are readily available to provide individual, personal assistance to members, family members and other concerned persons in understanding and utilizing the complaint, appeal and grievance processes.

OGA staff participates with CPSA Quality Management to conduct provider site reviews to ensure that providers post appropriate notices of member rights, advise members of and assist them in exercising their rights, and deliver all notice forms as required by DBHS policy. OGA staff also participates with CPSA Utilization Management to provide ongoing training of provider and CPSA staff and auditing of processes used to ensure compliance with notice requirements.

In addition to the information submitted to the DBHS Office of Grievance and Appeals database, the CPSA OGA maintains its own Access database that includes more detailed information about each appeal and grievance received. This information is regularly reviewed and tracked to identify trends or potential gaps that are then addressed through the CPSA quality improvement and network development processes. OGA staff regularly participates in Quality Management Coordinators' meetings to discuss overall trends identified and to receive input from provider quality management staff.

STAFFING OF THE CPSA OFFICE OF GRIEVANCE AND APPEALS

The Grievance and Appeals (G&A) Supervisor has overall responsibility for the operation and supervision of the OGA. This position oversees the development and implementation of all processes necessary to ensure the appropriate and timely processing of all appeals, grievances and provider claims disputes, including requests for Fair Hearings. The G&A Supervisor is responsible for ensuring that investigations of SMI grievances and provider claims disputes are conducted thoroughly and that conclusions and recommendations made to the CEO for issuing decisions are based on adequate findings of fact. The G&A Supervisor has primary responsibility for developing training materials and ensuring that staff and member education occurs on a regular basis. The position serves as the liaison to the DBHS Office of Grievance and Appeals and coordinates with other CPSA departments in ongoing efforts to develop information used in quality improvement and network development processes. The G&A Supervisor chairs appeal and informal conferences and investigates SMI grievances and provider claims disputes when necessitated by volume or potential conflicts. The G&A Supervisor must have a legal background, either as a licensed attorney, a graduate of an accredited law school, or a certified Arizona paralegal. Experience in health care, preferably behavioral health care, is desired as is a background in working with Medicaid issues.

The Grievance and Appeals Specialist facilitates the resolution of appeals and chairs appeal and informal conferences. The Specialist conducts investigations of SMI grievances and provider claims disputes and drafts investigation reports, including conclusions and recommendations, for review and approval by the G&A Supervisor. The G&A Specialist works directly with the G&A Office Assistant to ensure the timely scheduling of conferences, mailing of required communications and entry of information into the DBHS database. This position requires a bachelor's degree in behavioral health or social services and a minimum of three years experience in a health care related industry. Past training or experience in mediation and investigation are preferred, as are proficient writing skills.

The Grievance and Appeals Office Assistant is responsible for all clerical functions of the OGA, including docketing of all grievances and appeals, entry of all data into the DBHS and CPSA OGA databases, processing and mailing of all required communications, creating and maintaining case records and ensuring the timely delivery of those case records to DBHS and the AHCCCSA OLA when required. The G&A Office Assistant verifies Title XIX/XXI eligibility upon receipt of an appeal, obtains necessary releases of information and clinical records when needed. The G&A Office Assistant also schedules appeal and informal conferences and assures that participants are timely advised of date, time and location. This position requires, at minimum, an AA degree, two years experience in office assistance, and excellent customer services skills.

4-b3. Grievance and Appeal Processes

The CPSA process for handling complaints, grievances and appeals is a collaborative effort between CPSA Member Services and the CPSA Office of Grievance and Appeals (OGA). No portion of the process is delegated or subcontracted. CPSA adheres to ADHS/DBHS policies and procedures in implementing the process internally and posts on its Web site *Provider Manual* sections advising providers of their responsibilities. Those responsibilities include educating and assisting members in accessing complaint, grievance and appeal processes; providing timely, appropriate notices; and participating positively in reaching resolutions. The Manual also advises providers of their right to file claims disputes. The CPSA process is designed to encourage and facilitate resolutions quickly and fairly at the lowest level possible while maintaining open access to formal complaint, grievance and appeal processes. A logging and categorization function is built into the process so that pertinent information about complaints, grievances and appeals can be tracked and used to identify trends or potential gaps. These trends or gaps are then addressed through CPSA's quality improvement and network development processes. The specific process used to address an issue depends on the nature of the issue, the eligibility and enrollment status of the person involved, and choices available to certain individuals.

COMPLAINTS

CPSA has established a centralized complaint resolution process with Member Services serving as the designated area to receive, resolve, and track all complaints from members, their families or legal guardians, authorized representatives, persons seeking behavioral health services, other agencies, and the public. Member Services also receives and processes complaints referred from DBHS. In accordance with DBHS requirements, CPSA defines a complaint as "a member's expression of dissatisfaction with any aspect of his/her care, other than an issue that qualifies as an appeal of an action through the Title XIX/XXI member appeal process." Issues that qualify as an appeal, grievance or request for investigation under *Arizona Administrative Code*, Title 9, Chapter 21 are also distinguished from complaints, as are general requests for information.

Complaints are accepted by Member Services in writing or verbally, either by telephone or in person. CPSA advises potential members and members of telephone numbers and the mailing address to which complaints should be sent through its *Member Handbook*, information provided by and posted at provider sites, and the CPSA Web site. CPSA has established a toll free number for Member Services that is equipped with TTY (Teletypewriter) capacity, and Spanish speaking staff is always available to receive complaints. Oral interpretation in other languages is obtained when necessary. Member Services Representatives (MSRs) receive telephone calls from persons seeking information, voicing complaints or seeking to file appeals or grievances. MSRs provide general information requested and answer questions about the CPSA system of care. All Member Services staff involved in the complaint resolution process receive ongoing training and technical assistance from the CPSA OGA on distinguishing a complaint from a Title XIX appeal of an action or an appeal, grievance or request for investigation by a member with a serious mental illness. If the caller requests to file an appeal or grievance or is voicing a concern that could qualify as an appeal or grievance, the MSR transfers the caller to a Member Advocate or Member Services Specialist who assists the member in reducing the concern to writing and forwards it to the CPSA OGA to be docketed and logged. If the member agrees, the Member Advocate or Member Services Specialist may continue to assist the member in resolving the issue and will coordinate disposition with the OGA.

If the concern expressed by the person does not qualify as a grievance or appeal, the concern is referred to a Member Advocate who acknowledges receipt of the complaint within five working days, either by telephone or in writing. The Member Advocate assigned to assist the person in resolving the complaint contacts the person and offers to assist them with the resolution. The resolution may be accomplished by initiating phone calls, coordinating and/or participating in a Child and Family Team or Adult Clinical Team meeting, or by attending appointments with the member. All resolutions are accomplished and communicated to the member as expeditiously as possible and in no event later than 90 days, unless a 14-day extension is granted under the terms contained in DBHS policy. The Member Advocate seeks direction from the Chief Medical Officer (CMO) or the Associate Medical Director in resolving complaints involving clinical issues. In the event that the complaint was referred from DBHS, a written and oral summary of the resolution is submitted to DBHS within the timeframe specified by DBHS, and CPSA ensures that any specific actions directed by DBHS are implemented.

Member Services staff involved in receiving, acknowledging, responding to, and resolving complaints enter a description of each event and effort into the CPSA Member Services Tracking System (MSTS). At a minimum, the information tracked includes the individual or source making the complaint; the Title XIX/XXI eligibility status of the member involved; a description of the complaint; any identified communication need (e.g., need for a translator); the resolution

reached; and the length of time for resolution, including whether an extension was in effect. A log of this specified information about each complaint contained in MSTS is routinely developed and used to identify trends or potential gaps that are then addressed through CPSA's quality improvement and network development processes. This complaint log does not include information about issues received in Member Services that were identified as appeals or grievances and forwarded to the CPSA OGA for logging and processing.

TITLE XIX/XXI APPEALS

The CPSA OGA processes all Title XIX/XXI appeals. The OGA receives appeals both in writing and verbally, and has established and publicized a mailing address for written appeals and a local and toll free telephone number for verbal appeals. Contact information is included in the *CPSA Member Handbook*, *CPSA Provider Manual*, CPSA Web site, information posted at provider sites and on all appeal notice forms and other written documents addressed to Title XIX/XXI eligible persons. The OGA receives appeals directly from Title XIX/XXI eligible persons and their legal or authorized representatives, including providers acting on the person's behalf with his/her written consent. Additionally, the CPSA OGA processes as appeals all Title XIX/XXI appealable issues originally received by Member Services through the complaint process and forwarded to the OGA by Member Services.

Upon receipt of a Title XIX/XXI appeal, the Grievance and Appeals (G&A) Office Assistant creates a unique DBHS Docket Number in accordance with DBHS policy and enters required information into the DBHS Office of Grievance and Appeals database, in accordance with the *Office of Grievance and Appeals Database Manua*l. If the member has made a timely request to continue benefits during the appeal process, the Grievance and Appeals Supervisor (G&A Supervisor) contacts the involved Comprehensive Service Network (Network) to ensure that the contested service remains in place in accordance with DBHS policy.

Within five days of receipt of a standard appeal, the G&A Office Assistant sends the person filing the appeal an acknowledgment of receipt, written in the person's preferred language, by certified mail. Alternate formats, such as Braille or large font, are provided upon request. The acknowledgment letter advises the person of the appeals process and includes the minimum statements required by DBHS policy. The letter advises the person of the date, time and location of the appeal conference scheduled to receive, either personally and/or in writing, the member's evidence and allegations of fact or law. In most cases, the appeal conference is scheduled to occur no sooner than 15 days and no later than 25 days from receipt of the standard appeal. The correspondence requests the person to contact the CPSA OGA for additional information and advises the person that a CPSA Grievance and Appeals Specialist (G&A Specialist) will attempt to contact the person to discuss possible resolution of the appeal and explain the steps in the appeal conference process, if resolution cannot otherwise be reached.

Within seven days of receipt of an appeal, a G&A Specialist contacts the person filing the appeal to provide personal assistance in understanding the appeals process, completing forms, and taking other procedural steps required in the appeals process. The G&A Specialist discusses possibilities for resolving the appeal prior to the scheduled appeal conference and takes direct steps on behalf of the member and/or coordinates assistance through Member Services to resolve the issue in a manner acceptable to the member. The G&A Specialist discusses with the member his/her ability to examine the contents of the appeal case record at any point during the appeal and coordinates opportunities for the member to examine that record and all documents considered during the appeals process that are not protected by law from disclosure.

If the issue is resolved in a manner that the member acknowledges as acceptable prior to the date set for the appeal conference, the G&A Specialist sends to the member a written *Notice of Appeal Resolution* by certified mail, which clearly states the successful results of the resolution process and the date it was completed. The G&A Specialist conducts the appeal conference if a resolution has not been achieved prior to its scheduled date. The following participants are included in the conference: the member, his/her legal representative or advocate, and a representative with authority to represent and make decisions on behalf of the involved provider. The CMO or Associate Medical Director who has not been involved in any previous level of review or decision making and who has clinical expertise in treating the member's condition attends as the potential decision maker if an acceptable resolution cannot be reached by all parties. The CMO may designate a health care professional with clinical expertise in treating the member's condition to attend if the CMO is unavailable. Others may participate, subject to their availability, at the invitation of the member. Any party may attend telephonically by speaker phone, but conferences are never held via teleconferencing. CPSA provides interpreter services as necessary.

The G&A Specialist mediates the conference and affords the parties a final opportunity to offer and discuss compromises and propose solutions that might resolve the issue. If the issue is resolved at the appeal conference in a manner that the

member acknowledges as acceptable, the G&A Specialist commits that resolution to writing and sends to the member by certified mail a written *Notice of Appeal Resolution* clearly stating the successful results of the resolution process and the date it was completed. If the final mediation attempt is unsuccessful, the G&A Specialist affords the member the opportunity to present evidence and allegations of fact and law in person and in writing. At the close of an appeal conference that did not result in an agreed upon resolution, the G&A Specialist advises the parties that the CPSA CMO or Associate Medical Director who participated in the appeal conference will consider all of the information presented orally and in writing and will make a decision regarding the appeal. If a designee of the CMO attended the conference, he/she will consult with the CMO before a decision is reached. The standard of proof in reaching a decision is a preponderance of the evidence and the person who brought the appeal has the burden of proof.

The G&A Specialist reduces the decision to writing and sends to the member by certified mail a written *Notice of Appeal Resolution* clearly stating the decision and its factual and legal basis. The *Notice of Appeal Resolution* is delivered within 30 days of the date on which the appeal was received unless the member has requested an extension or CPSA needs additional information and an extension is in the member's best interest. In either case, the timeframe for issuing a decision may be extended for fourteen days. If CPSA extends the timeframe, the G&A Specialist provides written notice to the member explaining the reason for the delay. If the decision is not wholly in favor of the member, the *Notice of Appeal Resolution* advises the member of the right to request a State Fair Hearing and the process and timeframes for making that request. The notice also advises the member of the right to request to receive services while the State Fair Hearing is pending and circumstances under which the member may be liable for payment of those services if CPSA's decision is upheld by the State Fair Hearing.

CPSA conducts an expedited Title XIX/XXI appeal if it receives a request from a member, or a provider with written permission of a member, establishing that taking the time permitted for a standard appeal would seriously jeopardize the member's life or health, or ability to attain, maintain or regain maximum function. CPSA may conduct an expedited appeal on its own volition, without a request, if the facts included in the appeal demonstrate those same factors. Immediately upon receipt of an expedited appeal, a G&A Specialist contacts the person filing the appeal to arrange for an immediate opportunity to present personally and in writing evidence and allegations of law and fact in support of the appeal. Written acknowledgement of receipt of an expedited appeal is made within one day of receipt of the appeal and contains at a minimum the statements required by DBHS policy. During the three days following the receipt of an expedited appeal, the G&A Specialist attempts to resolve the appeal and assures that the CPSA CMO or Associate Medical Director reviews the information presented by the member. If a resolution cannot be agreed upon, the CPSA CMO or Associate Medical Director issues a decision that is communicated both in writing on a *Notice of Appeal Resolution* form and verbally to the member within three days of receipt of the appeal. CPSA will extend the three day timeframe by up to fourteen days if requested to do so by the member and may impose a like extension if the CMO or Associate Medical Director needs additional information and the extension is in the best interest of the member. If an extension is made, CPSA provides the member written notice of the reason for the delay and issues its decision as expeditiously as the member's health condition requires.

APPEALS FOR PERSONS WITH A SERIOUS MENTAL ILLNESS (SMI)

The CPSA OGA processes all appeals filed by or on behalf of persons determined SMI eligible and persons disputing an SMI determination. Personnel from both CPSA Member Services and the CPSA OGA provide assistance in explaining the appeals process and in reducing appeals to writing on an appeal form. Member Services personnel receive ongoing training on who may file an SMI appeal and timeframes for filing. They are also trained to recognize the 14 issues that qualify as SMI appeals and to refer those issues to the OGA for processing if they are received as complaints. Both Member Services and OGA personnel are trained in the distinctions between the Title XIX/XXI appeal process and the appeal process for persons with a serious mental illness and will advise Title XIX/XXI eligible persons with serious mental illness who are appealing an action affecting a Title XIX/XXI service that they may elect to use either process.

Upon receipt of an SMI appeal, the G&A Office Assistant creates a unique DBHS Docket Number in accordance with DBHS policy and enters required information into the DBHS Office of Grievance and Appeals database, in accordance with the *Office of Grievance and Appeals Database Manual*. The G&A Supervisor reviews the appeal to determine whether it is timely filed and whether it contains an appealable issue. Late appeals are accepted upon showing of good cause. If it is determined that CPSA will not accept the appeal, the member is notified in writing and advised that he/she may, within ten days of receipt of the notice, request an administrative review of the decision by the DBHS Office of Grievance and Appeals.

If the appeal is accepted, a G&A Specialist immediately attempts to contact the member by telephone to provide personal assistance in understanding the appeals process, including further explanation of the distinctions between the

SMI and the Title XIX/XXI processes. The G&A Specialist discusses possibilities for resolving the appeal and, if the member agrees, takes direct steps on behalf of the member and/or coordinates assistance through CPSA Member Services to resolve the issue in a manner acceptable to the member.

If the member elects the SMI appeal process, the G&A Office Assistant makes telephone contact to determine a convenient time for the member to attend an informal conference and to identify persons to be included in the conference. Within three days of receipt of the appeal, the CPSA G&A Office Assistant sends by certified mail to the person filing the appeal an acknowledgment of receipt written in the person's preferred language. Alternate formats such as Braille or large font are provided upon request. The acknowledgment letter advises the person of the procedures that will be followed during the appeals process, including the member's ability to participate in the informal conference by telephone and to be represented by a designated representative of his/her choice. The letter specifies the date, time and location of the informal conference scheduled to occur within seven days from receipt of the appeal unless the member has requested an extension of the timeframe or the CPSA Chief Executive Officer (CEO) has otherwise approved an extension based on necessity and a showing that the delay will not pose a threat to the safety or security of the member. The letter advises the member that he/she may examine the contents of the appeal case record and all documents that are not protected by law from disclosure and that will be considered during the informal conference and any subsequent administrative hearing. If the appeal pertains to the modification or termination of services, the letter advises the person that the services will remain in place throughout the appeals process under most circumstances and that the member will not be responsible for payment of the services.

If the issue is resolved in a manner that the member acknowledges as acceptable prior to the date set for the informal conference, the G&A Specialist sends to the member by certified mail a written notice of resolution clearly stating the successful resolution results and advising the member that the appeal record has been closed.

The G&A Specialist conducts the informal conference if a resolution has not been achieved prior to its scheduled date. The following participants are included in the conference: the member; his/her legal representative, advocate or designated representative; a representative with authority to represent and make decisions on behalf of the involved provider; and, the CPSA CMO or Associate Medical Director, or designee. Others may participate, subject to their availability, at the invitation of the member. Any party may attend telephonically by speaker phone, but informal conferences are never conducted via teleconferencing. Interpreter services are provided as necessary. The G&A Specialist, who has authority to resolve the issues under appeal, mediates the conference and affords the parties an opportunity to offer and discuss compromises and propose solutions that might resolve the issues. If the issues are resolved at the informal conference in a manner that the member acknowledges as acceptable, the G&A Specialist issues a written notice to the parties that includes a statement of the issues involved, the resolution achieved, who is responsible for implementing the resolution, and the date by which the resolution will be implemented. If any or all of the issues are not resolved, and do not involve determination of the person's SMI eligibility, the G&A Specialist advises the member that the matter will be forwarded for an informal conference with DBHS and the process for requesting a waiver of that conference. If the member does not waive the DBHS informal conference, the G&A Specialist notifies the DBHS Office of Grievance and Appeals of the member's choice and forwards the appeal case record to the DBHS OGA within three days of the CPSA informal conference. The CPSA G&A Office Assistant coordinates with DBHS staff on arrangements for the DBHS informal conference.

If the member requests a waiver of the DBHS informal conference or the unresolved issue involves a person's eligibility for SMI services, the G&A Specialist provides written notice of the process for requesting an administrative hearing and determines whether the member would like CPSA to request a hearing on his/her behalf. If so, CPSA OGA staff files the request with and forwards the appeal case record to DBHS within three days of the informal conference. If the G&A Specialist determines that the member is in need of special assistance to participate in the hearing process, he/she makes a referral to the appropriate human rights committee.

The CPSA OGA handles the appeal process for persons with serious mental illness on an expedited basis upon request when the appeal involves the denial of admission to or termination of an inpatient service or a termination of crisis or emergency services. Under the expedited process, written acknowledgment of receipt and notification of the informal conference date, time and place are provided within one day of the request's receipt and the informal conference is held within two days of that receipt.

NON-SMI/NON-TITLE XIX/XXI MEMBER APPEALS

Upon receipt of an appeal filed by a Non-SMI/Non-Title XIX/XXI member, the CPSA G&A Office Assistant dockets the appeal and enters required information into the ADHS/DBHS Office of Grievance and Appeals database. Within

five days of receipt, the G&A Office Assistant sends a letter acknowledging receipt of the appeal and outlining the procedures to be followed in the appeal process including the date, time and place scheduled for the member to present evidence and allegations of fact or law. A G&A Specialist conducts the scheduled meeting with the member, receives the evidence presented, and reviews the case with the CPSA CMO or Associated Medical Director. Based on the decision of the CMO, and within 30 days of receipt of the appeal, the G&A Specialist provides the member with a written decision, including a summary of the issues involved, the outcome of the appeal, the basis of the decision, and the process that must be followed to obtain an administrative hearing of the decision. If the member submits a request for administrative hearing to CPSA, the G&A Office Assistant forwards the request in writing, along with the appeal case record and supporting documentation, to the DBHS Office of Grievance and Appeals within three days.

INVESTIGATION OF GRIEVANCES FILED BY PERSONS WITH SERIOUS MENTAL ILLNESS

The CPSA OGA processes as grievances or requests to investigate all complaints, submitted verbally or in writing by a person with SMI or other concerned person, regarding a violation of rights of the person with SMI or an incident or condition that appears to be dangerous, illegal or inhumane, including the death of a person with SMI. The OGA takes immediate steps reasonably necessary to protect the health, safety and security of any member, complainant or witness identified in a grievance request. The grievance or request to investigate is reviewed by the G&A Supervisor immediately upon receipt and any oral report is reduced to writing. If the report contains allegations of sexual or physical abuse or involves the death of a member, it is forwarded to the DBHS OGA for investigation, otherwise it is docketed and required information entered into the DBHS Office of Grievance and Appeals database. The G&A Supervisor evaluates all other allegations to determine whether they are subject to summary disposition (alleged violation occurred over one year ago or allegation involves an appealable issue) or may be fairly disposed of or resolved without investigation (there is no dispute of the facts or the allegation is frivolous). For either of these preliminary dispositions, the G&A Supervisor prepares a written decision explaining why the matter may be resolved without investigation and containing information on appeal rights and how to request assistance from state and federal advocacy agencies. Upon approval of the CPSA CEO and within seven days of receipt of the grievance, the written decision is sent to the person filing the grievance and to the DBHS Office of Human Rights, if the person involved is in need of special assistance.

Those grievances not subject to preliminary disposition are assigned to a G&A Specialist for investigation, and written notice of that assignment is sent to the grievant within seven days of receipt of the grievance. Within ten days of appointment, the investigator holds face-to-face interviews with the member and the person who filed the grievance. The investigator arranges for an advocate to assist the member during the interview if necessary. The alleged perpetrator of the rights violation is then interviewed followed by any other witnesses identified in the course of the investigation. The investigator also gathers and reviews all documentation, including medical records, necessary to reach a conclusion. Within thirty days of appointment, the investigator submits to the CPSA CEO a written report summarizing the interviews conducted and the information reviewed and setting forth findings of fact, conclusions and recommendations. The CEO can accept the report or request additional investigation or information. Within five days of receipt of an accepted report, the CEO issues and sends to the grievant a written decision summarizing the findings and conclusions and any corrective actions required. The decision includes a notice of the right to request and the process to follow to obtain an administrative appeal of the decision. If an administrative appeal is filed, the CPSA G&A Office Assistant forwards to the DBHS Office of Grievance and Appeals a copy of the full investigation case record. The CPSA OGA oversees implementation of, and compliance with, any required corrective actions.

PROVIDER CLAIMS DISPUTES

Providers receive written notification of their right to file a claim dispute whenever a claim for payment is denied in whole or in part, or a decision is made to impose a sanction. The CPSA OGA processes all disputes filed by providers involving payment of a claim, denial of a claim or imposition of a sanction. The OGA accepts written claims disputes that are filed by providers within the timeframes specified by DBHS policy and that contain required information, including a statement of the factual and legal basis for the dispute and the relief requested. Claim disputes are docketed and entered into the DBHS Office of G&A database immediately upon receipt. Within five days of receipt, the OGA sends a written acknowledgement to the provider that the claims dispute has been received and that a decision will be issued within thirty days of that receipt. A G&A Specialist investigates the dispute and develops a written proposed decision that is submitted to CPSA's CEO. Within 30 days of the dispute's receipt and based on the OGA investigation, the CEO issues a written, dated decision that either grants or denies the relief requested and is sent by certified mail to the provider. The decision includes the reason for the decision and the legal and policy considerations involved. It also includes a statement of the provider's right to file a request for an administrative hearing with the DBHS Office of G&A.

4-b4. Communication of Member Rights

CPSA is proactive in clearly communicating grievance and appeals information to members and in educating both staff and members on grievance and appeals rights and the processes for exercising those rights. CPSA takes affirmative steps to ensure that all communication is in easily understood language and formats and in prevalent non-English languages for members with Limited English Proficiency (LEP). As a guide, CPSA has adopted the four language access standards delineated in the *National Standards for Culturally and Linguistically Appropriate Services (CLAS)* issued by the Office of Minority Health.

CULTURALLY COMPETENT PROVIDERS AND STAFF

CPSA has secured the availability and accessibility of competent language-access services through direct contracts with culturally driven resource agencies specializing in translation and interpretation services. To insure that all members can access information about the grievance and appeals process in the language in which they feel most proficient, CPSA has secured a letter of intent with Tucson-based CyraCom International, an all languages, telephone interpreter service that specializes in medical and mental health settings. CPSA provides free interpretation services for the hearing impaired through a contract with the Community Outreach Program for the Deaf (COPD) and through TTY (Teletypewriter) telephone services. Braille transcription is available through a number of community-based organizations serving the visually impaired. CPSA also has partnerships with state agencies to address the special communication needs of dually enrolled Division of Developmental Disability (DDD) members. CPSA will continue to partner with providers who demonstrate proficiencies in communicating effectively with these special needs populations.

To enhance the system's ability to provide clear and understandable communication with all members, CPSA works collaboratively with its Comprehensive Service Networks (Networks) to recruit, retain and train a culturally and linguistically proficient workforce. These efforts are promoted through the monthly Human Resources (HR) Provider meeting facilitated by CPSA's Human Resources Manager and attended by Network HR staff. To ensure competent bi-lingual communication skills, CPSA is developing a contract with Rios and Associates, a company with a long history of providing cultural and linguistic training for the medical community, under which Rios will develop and implement linguistic and cultural assessment tools and training protocols to enhance and develop culturally and linguistically competent behavioral health staff. CPSA is also working with university-level social work programs and both Cochise and Pima Community Colleges to develop multiple levels of continuing education for social service/behavioral health workers. These programs weave culture and language training throughout course work and also provide specialized language classes oriented towards behavioral health linguistic proficiency standards.

GRIEVANCE AND APPEAL TRAINING

CPSA believes that information about grievance and appeals rights and processes is best communicated in person by knowledgeable and well-trained staff. To this end, the CPSA Office of Grievance and Appeals (OGA) develops and provides ongoing training for provider and internal CPSA staff on members' rights to file appeals and grievances. These trainings delineate staff members' responsibilities to educate members about the appeal and grievance processes, to clearly explain how those processes are accessed and to take affirmative steps to address a member's special communication needs in understanding those processes. Training emphasizes staff members' responsibilities to personally assist members in filing appeals and grievances and to identify members who need special assistance to fully understand and participate in the grievance and appeals processes. Training is provided on the mechanisms staff members should use to access available special communication services to ensure members' comprehension of their rights. Training reinforces staff members' additional responsibility to refer members in the program for persons with serious mental illness (SMI) who are determined to be in need of special assistance to the ADHS Office of Human Rights and their respective GSA 3 or GSA 5 Human Rights Committee for assistance in understanding and navigating the grievance and appeals processes.

The CPSA OGA coordinates ongoing training for members, legal guardians, family members and community stakeholders on member rights, including the right to file and the process to use when filing grievances and appeals. CPSA Member Services and OGA personnel are readily available to provide individual, personal assistance to members, family members and other concerned persons in understanding and utilizing the appeal and grievance processes. Bi-lingual staff is available in both GSAs to assist whenever necessary.

CPSA MEMBER HANDBOOK

The *CPSA Member Handbook*, published in both English and Spanish, contains detailed, easily understood information on the grievance and appeals process. The Handbook includes CPSA-specific language on who to contact to file appeals or grievances, how to obtain information and assistance with the grievance and appeals process, and how to voice

complaints. Annual updates of the *CPSA Member Handbook* are approved by DBHS and delivered by CPSA to the Networks for distribution to members. CPSA designates to the Network Clinical Liaisons the responsibility of providing current Member Handbooks to all CPSA members at the time of initial assessment and on an annual basis thereafter. The assigned Clinical Liaison ensures that each member understands the information contained in the Member Handbook. If the member is unable to read or understand the Handbook, the Clinical Liaison arranges for interpretation or an alternative format that the member can understand. The Clinical Liaison is responsible for answering the member's questions and explaining the information in the Handbook. Receipt and comprehension of the Member Handbook is documented in each member's comprehensive clinical record and monitored by CPSA during the annual Provider Profile Review. Additional copies of the Member Handbook are provided to community stakeholders, advocacy agencies and CPSA providers so that they can be readily accessible and they are also available through CPSA Member Services. The Member Handbook is prominently posted on the CPSA Web site, which will be fully compliant with the Americans with Disabilities Act (ADA) by the beginning of the new contract year.

NOTICE FORMS

CPSA and its providers use DBHS notice forms to advise persons of their grievance and appeals rights. These notice forms are translated into Spanish, (the only prevalent or commonly encountered non-English language in both GSA 3 and GSA 5), and are delivered and/or posted by CPSA and Networks as required by DBHS policy. Most notice forms are delivered personally as part of the treatment planning process. This personal delivery enhances the opportunity for CPSA and Network staff to answer questions and thoroughly explain to members their appeal rights and the process to follow in exercising those rights. Personal delivery provides the opportunity for the staff member to assess the member's communication needs, advise the member of the availability of services to address special communication needs, and address those needs through translation services, free oral interpretation and alternative formats such as Braille, large font and enhanced audio. All notice forms provide the name and contact number for the person responsible for providing additional information about the specific decision addressed by the notice. Notice forms include contact numbers for CPSA Member Services, the CPSA OGA and other state and federal advocacy agencies. The forms clearly advise, in both English and Spanish, that translation and alternative formats are available and how to request those services. This written information on how to access information and assistance with the appeals process is especially valuable in circumstances where notice must be delivered through certified mail.

Free, oral Spanish interpretation is provided at appeal and informal conferences when necessary to assist members in understanding and navigating the appeals process. The OGA arranges provision of free, oral interpretation services in other languages to explain information contained in notices and other appeal process correspondence and to allow members to participate in appeal and informal conferences. The OGA also ensures that alternative formats, such as TTY (Teletypewriter), can be accessed when needed and that notice forms and other written documents and correspondence related to the appeals process are made available in alternate formats such as Braille, large font or enhanced audio.

MONITORING COMMUNICATION REGARDING GRIEVANCE AND APPEALS

CPSA OGA staff participates with CPSA Quality Management to conduct provider site reviews to ensure that providers post appropriate notices of member rights, advise members of, and assist them in, understanding and exercising their rights and deliver all notice forms as required by DBHS policy. The OGA staff also participates with CPSA Utilization Management staff to provide ongoing training of provider and CPSA staff as well as auditing of processes used to ensure compliance with notice requirements.

CPSA will continue to use nationally developed standards and DBHS policies and procedures as guidance in ensuring that all members receive clear, concise and appropriate information regarding their grievance and appeal rights and the processes for exercising them. Well trained, culturally competent staff members and the best use of technology are tools CPSA will continue to use to maintain this aspect of quality care.